CHEMAWAWIN FIRST NATION
BAND OF INDIANS

Easterville, Manitoba

By-law for the Establishment
of The Chemawawin First Nation Health Board
and OTHER RELATED MATTERS

CERTIFIED to be a true copy of a By-law of
The Chemawawin First Nation Band of Indians
passed by Chief and Council of the
Chemawawin First Nation Band of Indians
this 24th day of January , 1989

Alpheus Brass

CHIEF ALPHEUS BRASS

CHEMAWAWIN FIRST NATION
HEALTH AUTHORITY BY-LAW

Preamble

WHEREAS the Chemawawin First Nation peoples have a right to health services at an adequate and proper level to meet their health requirements;

AND WHEREAS the Chemawawin First Nation entered into solemn Treaty arrangements with Her Majesty's Government of the Dominion of Canada by adhesion to Treaty Number 5;

AND WHEREAS the Chemawawin First Nation did not, through said Treaty give up their authority to be a self-governing people;

AND WHEREAS the Chief and Council of Chemawawin First Nation desires by this by-law to take over responsibility for the delivery of health and related services and programs;

AND WHEREAS Section 81 (1) (a), (d), (f), (g), (h), (j), (l), (q), and (r) of the Indian Act R.S.C. 1970 Ch. 1 - 6 as amended empowers the Chemawawin First Nation to make by-laws inter alia;

(a) To provide for the health of residents on the reserve and to prevent the spreading of contagious and infectious diseases;

(d) The prevention of disorderly conduct and nuisances;

(f) the construction and maintenance of water courses, roads, bridges, ditches, fences and other local works;

(g) The dividing of the reserve or a portion thereof into zones and prohibition of the construction of buildings or the carrying on of any class of business, trade or calling in any such zone;

(h) The regulation of the construction, repair and use of buildings, whether owned by the Band or by individual members of the Band;

(j) The destruction and control of noxious weeds;

(l) The construction and regulation of the use of public wells, cisterns, reservoirs and other water supplies;

(q) With respect to any matter arising out of or ancillary to the exercise of powers under this section;

(r) The imposition on summary conviction of a fine not exceeding one thousand dollars or imprisonment for a term not exceeding thirty days, or both, for violation of a by-law made under this section.

AND WHEREAS Section 36 of the Constitution Act, 1982 provides that without altering legislative authority of Parliament or of the Provincial Legislatures, or the rights of any of them with respect to the exercise of their legislative authority, Canada and Manitoba are committed to:

a) Promoting equal opportunities for the well being of Canadians;

b) Furthering economic development to reduce disparity in opportunities; and

c) Providing essential public services of reasonable quality to all Canadians.

AND WHEREAS the Chemawawin First Nation defines health in the same terms as endorsed by the World Health Organization as a state of complete physical, mental and social well being and not merely the absence of disease or infirmity.

AND WHEREAS the health conditions of the Chemawawin First Nation Indian Reserve cannot be significantly improved without Indian involvement in and control of local health care services.

AND WHEREAS the Chemawawin First Nation peoples desire their Chief and Council to create, maintain and operate a local health authority on their reserves.

AND WHEREAS pursuant to Section 73 of the Indian Act, the Government of Canada has enacted certain regulations respecting health and waste disposal.

AND WHEREAS the Chief and Council has by Band Council Resolution has requested the Minister to exempt Chemawawin Indian Band from said regulations and enable this by-law to supercede said regulations.

AND WHEREAS the Chemawawin First Nation was not a party to the Memorandum of Agreement entered into in 1964 between the Medical Services Branch and Manitoba Health and is therefore not bound by that Agreement.

AND WHEREAS nothing in this by-law shall alter, diminish, abrogate, derogate or breach the Treaty and or Aboriginal rights of the Chemawawin Band of Indians or its members.

AND WHEREAS further, nothing in this by-law shall alter, diminish, abrogate, derogate or breach the Treaty status of the Chemawawin Band of Indians or its members under Treaty Number 5 with Her Majesty's Government of Canada, nor shall it be interpreted or construed to do so.

BE IT ENACTED AND THEREFORE IT IS HEREBY ENACTED as a By-Law of the Council of the Chemawawin First Nation herein called the "Band Council" as follows:

Council Authorized to Obtain Agreements for Local and Regional Health and Related Services

1. The Band Council is hereby authorized to enter into such agreements and declarations as in its sole discretion it deems appropriate, to create, maintain and operate a Chemawawin First Nation Health Board (hereinafter referred to as the "Board") to serve the community health needs of the Chemawawin First Nation.

Establishment of Chemawawin First Nation Health Board

2. The Band Council hereby enacts and it is hereby enacted and established that there shall be a Chemawawin First Nation Health Board hereinafter referred to as the "Board".

3. The community health service needs of residents on-Reserve shall be administered, delivered and maintained by the Board. The Board shall be guided

initially by the Chemawawin First Nation Health Policy Manual (hereby incorporated by reference to this by-law and attached hereto as Appendix "A"). The Board shall in the future make recommendations to the Band Council for the revision of the policies set out in the said manual as changing conditions require.

4. The Band Council shall appoint the Chemawawin Health Board and said Board shall be responsible and accountable to the Band Council.

a) A Director's term of office, subject to future Band by-laws, shall be for a four year term or until a successor is appointed by Chief and Council.

b) Vacation of Office. The office of Director shall be vacated automatically:

i) if by notice in writing to the Board he resigns his office;

ii) if he dies;

iii) if he misses three consecutive Board meetings without a reasonable excuse;

iv) if he is found to be of unsound mind;

v) if he is dismissed for "just cause" by the Band Council.

c) The Band Council has authority to dismiss Board members for "just cause". Change in the composition of the Chief and Council shall not be "just cause" within the meaning of this clause. Such matters as serious misconduct, breach of confidentiality, failure to responsibly perform the duties of a Board member, missing meetings too frequently, or conviction for a serious criminal offence may fall within the definition of "just cause".

d) The Directors shall establish operating procedures of the Board and dealing, inter alia, with such matters as meetings, duties of Directors, the establishment of Board Committees to monitor, evaluate and assess the various programs that are delivered by the Board.

e) The Directors shall meet not less than 10 times per year. The Directors are empowered to include in their operating procedures a provision for meetings by telephone conference where circumstances warrant.

Board of Directors

5. a) The Board shall consist of seven members, five of whom shall be voting members and at least four of whom must be members of the Chemawawin Indian Band.

b) In appointing the Directors, Chief and Council shall be guided by the need to provide representation on the Board from the following elements of the Chemawawin First Nation Community:

* Representation from the Chemawawin First Nations elders;
* Representation from youth (ages 18 to 30)
* Representation by persons knowledgeable on health issues of the community.

c) There shall be representation by a Band Councillor for the Chemawawin First Nation with responsibility for the Health Portfolio. Said Councillor shall sit as an ex officio member and shall have no vote at board meetings.

d) The Community Council for the Community of Easterville may designate a Board member and the Chief and Council may appoint such person as a member of the board.

e) The Board is hereby authorized to select a chairman from amongst their midst and to appoint such other officers as they may see fit. The chairman shall not have a vote except in the event of a tie vote in which case the chairman shall cast the deciding vote.

f) Sitting Board members are eligible for reappointment at the expiry of their term.

g) Persons employed by the Board shall not be eligible for Board membership.

h) A quorum of the board shall be four, at least three of whom must be voting members.

Health Care Administrator to Attend All Board Meetings

6. The Health Care Administrator selected by the Board shall have, as part of his job description, an obligation to attend all meetings of the Chemawawin First Nations Health Board.

Confidentiality of Client/Patient Records

7(1) Subject to this by-law, client/patient records made under this by-law and the Chemawawin Health Policy are confidential and no person shall disclose or communicate information from the record in any form to any person except:

a) to the Chemawawin Health Care Administrator, or to a person employed, retained or consulted by said Health Care Administrator in the course of administering or enforcing any provision of this by-law or the Chemawawin Health Care Policy;

b) to the client/patient in question provided that release of the information to the client/patient has been approved by the Chemawawin Health Care Administrator;

7(2) A client/patient of the Chemawawin Health Authority is entitled to be given access to:

i) his or her own records; and

ii) the record of a child who is in the adult's legal care subject to the exceptions contained in paragraph 7(3) herein;

7(3) The Chemawawin Health Care Administrator may refuse to give a person access to all or any part of a record referred to in 7(2) where:

a) There are reasonable grounds to believe that disclosure of all or part of the record might result in physical or serious psychological harm to that person;

b) That part of the record discloses the identity of a person who is not employed by the Chemawawin Health Authority and who has supplied information in confidence to the Chemawawin Health Authority for any purpose relating to the administration or enforcement of this by-law or the Chemawawin Health Policy;

and the Chemawawin Health Care Administrator shall notify the person in writing of the reasons for refusing access to all or any part of his or her record or the record of a child in his or her care.

7(4) It shall be stipulated in every contract of employment that the Board enters into that employees are undertaking to protect and honour the special relationship and confidentiality that exists between the Health Board and its clients/patients. It shall be further stipulated that breach of such confidentiality may be grounds for dismissal.

7(5) It shall be the duty of every Director of the Board to comply with the confidentiality provisions of this by-law and should a Board member breach said confidentiality provisions it shall be grounds for the dismissal of that Board member from his position by the Band Council.

The Board May Negotiate Agreements

8(1) The Band Council hereby authorizes the Board to negotiate agreements with other Swampy Cree Tribal Bands, the Federal Government, the Provincial Government, public health services agencies, or other private health services agencies, or other such agencies pursuant to the Chemawawin Health Policy Manual for the delivery of regional or community health services to residents including, inter alia, the provision of or construction of health services facilities, the provision of health services staff and personnel including, inter alia, physicians, community health representatives, dentists, dental assistants, dental therapists, nurses, midwives, traditional Indian healers, medical officers of health, environmental health officer, and other necessary personnel;

8(2) Without restricting the generality of the foregoing, the Band Council hereby authorizes the Board to negotiate agreements for the maintenance and construction of nursing stations or other health care delivery facilities.

8(3) All such agreements shall be brought to the Band Council for approval and ratification.

Responsibilities of the Board

9(1) The Board shall be responsible for the overall administration, maintenance and delivery of

health services in the community and without restricting the generality of the foregoing may:

a) Develop operating procedures for the Board;

b) Recommend administrative, personnel, financial, and other policies;

c) Receive and approve budget;

d) Subject to the approval and ratification of the Band Council, borrow and spend money and acquire, dispose of and manage all forms of personal property;

e) Manage such real property as the Band Council may direct;

f) Review and approve the Annual Report;

g) Provide an Annual Report to the Chief and Council and consult from time to time with Chief and Council on the health needs of the community;

h) Hire and dismiss a qualified Health Care Administrator;

i) Advise the Band Council on health and health related policy matters;

j) Ensure that policies and procedures are in place to maintain the traditional confidentiality of medical records.

10. The Board may enter into agreements for the retention of a qualified Health Care Administrator who shall be responsible and accountable directly to the Board and who shall be the senior health services staff officer.

11. The Board shall have the power to maintain, control, and manage the affairs of the various health and related activities of the Chemawawin First Nation, and the power to disburse funds up to the amount of the budget approved by the Band Council and where necessary, any parties to any agreements made pursuant to this by-law and to disburse any other grants, fees, donations or other monies received by the Authority in the course of operating their programs and activities pursuant to the Chemawawin Health Policy Manual.

Duties of Health Care Administrator

12(1) The Board may determine from time to time the duties and responsibilities of the qualified health care administrator and without restricting the generality of the foregoing the qualified health care administrator shall be responsible for:

a) organizing and managing the day to day business of the Health Authority;

b) establishing procedures to implement policies contained in the Chemawawin Health Policy Manual;

c) personnel administration and supervision of health services and staff including the power to hire and fire, subject always to such policy as to appeals or grievances as may be established by the Board;

d) financial administration;

e) program supervision;

f) liaison with other agencies;

g) managing all arrangements contracted for with others;

h) reporting to the Board on all the above mentioned matters in such form and on such schedules as the Board may from time to time determine.

Staffing and Personnel

13. The Board may determine from time to time the duties and responsibilities and the number of staff and personnel of the Board and without restricting the generality of the foregoing including, inter alia, dental assistants, dental therapists, nurses, midwives, traditional Indian healers, medical officers of health, environmental health officers, clerks, and other necessary personnel.

14. The Board may recognize persons who act as traditional Indian healers and may provide for a method of any remuneration or any compensation to the traditional Indian healers for such services.

Program and Services

15(1) The Chemawawin First Nation is not a party to the Memorandum of Agreement between the Federal Government of Canada and the Province of Manitoba entered into in 1964. The Chemawawin First Nation, Band Council, and Board is not bound by the said 1964 Agreement.

15(2) The Board is hereby mandated, subject to negotiations involving Canada, the Band Council, the Community Council of Easterville and the Province of Manitoba to establish a nursing station on the Chemawawin First Nation Reserve Lands within twelve months of the enactment of this by-law.

15(3) The Board shall administer, manage, maintain and deliver, in accordance with the Health Transfer Agreement between the Minister of National Health and Welfare and the Chemawawin Band, the following health services and programs and it is hereby enacted that at a minimum specific Provincial standards relating to such programs shall apply until such time as there may be an Agreement to the contrary between the Minister of Health and Welfare for Canada and the Chemawawin Band.

a) Those treatment services contained in Health and Welfare Canada's Health Program Transfer Handbook dated September 28, 1989 and any amendments thereto;

b) Communicable disease control;

c) Occupational and environmental health and safety;

d) Emergency health planning.

16. The Board shall administer and maintain such other local health services as are determined by the Band Council to be required to be administered, maintained, and delivered to members of the Chemawawin First Nation.

Enforcement and Penalties

17. Insofar as they are not inconsistent with this by-law or any future by-law, specific provincial laws and regulations relating to the matters mentioned in paragraphs 15(3)(a), (b), (c), and (d) are hereby

incorporated as part of this by-law and may be enforced as part of this by-law, until such time as the Band Council may otherwise agree with the Minister of Health and Welfare for Canada.

18(1) The Board may, from time to time, recommend to the Chief and Council:

a) Amendments to this by-law;

b) The enactment of further by-laws to create or give effect to programs required for the health and well being of members of the Chemawawin First Nation;

c) Other measures that may be required to enable the Board to carry out its duties and responsibilities.

19. The Board is hereby authorized to take any action necessary to ensure this by-law or policy established thereunder is complied with.

20. The Board may consult with the Band Council when enforcing this by-law or ensuring compliance with this by-law.

21. This by-law shall be enforced by Band Constables or any other Peace Officers serving the Chemawawin Band or by inspectors employed or designated by the Board.

22. Every individual, person or corporate body shall comply with this by-law and the laws and regulations referred to in paragraph 17.

23. A violation of this by-law that continues for more than one day constitutes a separate offence for each day during which it continues.

24. Any individual, person or corporate body who violates any of the provisions of this by-law shall be guilty of an offence, and shall be liable on a summary conviction to a fine not exceeding $1,000.00 or imprisonment for a term not exceeding 30 days, or to both a fine and imprisonment, for each violation.

Interpretation

25. In this by-law, the masculine includes the feminine, the feminine the masculine and the singular includes the plural and the plural the singular as the context requires.

Severability

26. In the event that a Court of competent jurisdiction or other body with jurisdiction determines that any provision herein is unlawful or beyond the jurisdiction of the Chief and Council, and/or the Government of Canada, said provision shall be severable from this by-law and the remainder of the terms of the by-law and any regulations thereunder or future by-law shall remain in full force and effect.

For the Protection of Directors and Officers

27. No Director or Officer of the Board shall be liable for:

a) the acts, receipts, neglects or defaults of any other director or officer or employee;

b) for joining in any receipt or act for conformity;

c) for any loss, damage or expense happening to the Board through the insufficiency or deficiency to title to any property acquired for or on behalf of the Board;

d) for the insufficiency or deficiency of any security upon which any of the monies of the Board are placed or invested;

e) for any loss or damage arising from the bankruptcy, insolvency or tortious act of any person, firm or corporation with which any monies, securities or effects shall be deposited or lodged;

f) for any loss, conversion, misapplication or misappropriation of, or any damage resulting from any dealings with any monies, securities, or other assets belonging to the Board;

g) for any other loss, damage or misfortune whatever;

unless the above shall happen by his failure to exercise the powers and to discharge the duties of his office of trust honestly in good faith and in the best

interests of the Board, and to exercise the degree of care, diligence and skill that a reasonable prudent person would exercise in comparable circumstances.

Indemnities to Directors and Officers

28. Subject to the provisions of this by-law, every Director and Officer of the Board, his heirs, executors, administrators, and other legal personal representatives and persons acting on instruction of the Board shall be indemnified by the Board for:

a) any liabilities, costs, charges and expenses that he sustains or incurs in respect of any action, suit or proceeding that is proposed or commenced against him in respect of the bona fide execution of the duties of his office; and

b) all other charges, expenses which he sustains or incurs in respect of the affairs of the Board.

DONE AND PASSED by Chief and Council in Council assembled this 24th day of January, A.D., 1989.

THE CHEMAWAWIN BAND OF INDIANS

Per:

Stephen Bisaillon — Percy George

Chief

Roderick George (Councillor) — Michael George

Wm Ratt. —

William Ratt —

(A QUORUM FOR THIS BAND CONSISTS OF FOUR (4) COUNCIL MEMBERS)

Indian and Northern Affairs Canada / Affaires indiennes et du Nord Canada

Chronological No. – N° consécutif
File Reference – N° de référence du dossier

BAND COUNCIL RESOLUTION
RÉSOLUTION DE CONSEIL DE BANDE

NOTE: The words "From our Band Funds" "Capital" or "Revenue", whichever is the case, must appear in all resolutions requesting expenditures from Band Funds.
NOTA: Les Mots "des fonds de notre bande" "capital" ou "Revenu" selon le cas doivent paraitre dans toutes les résolutions portant sur des dépenses à même les fonds des bandes

The council of the / Le conseil de la bande indienne	CHEMAWAWIN FIRST NATION	Current Capital Balance / Solde de capital $
Agency / District	EASTERVILLE	Committed / Engagé $
Province	MANITOBA	Current Revenue Balance / Solde de revenue $
Place / Nom de l'endroit	EASTERVILLE	
Date	24 (Day – Jour) January (Month – Mois) AD 19 90 (Year – Année)	Committed / Engagé $

DO HEREBY RESOLVE:
DÉCIDE, PAR LES PRÉSENTES:

WHEREAS: The Indian Act in Section 81 empowers the Chief and Council of the Chemawawin First Nation to enact by-laws respecting the health of residents of the reserve and other related matters;

AND WHEREAS; The said Indian Act in Section 73 also empowers the Governor in Council to make regulations respecting certain aspects of Indian Health;

AND WHEREAS; The Minister has, through Section 73 of the said Indian Act, enacted the Indian Health Regulation, C.R.C. 1978, C 955 and the Indian Reserve Waste Disposal Regulation, C.R.C. 1978, C 960;

AND WHEREAS; The Chief and Council of the Chemawawin First Nation has this day enacted a By-law, the purpose of which is to take over responsibility for and establish a complete Health Care service for the Chemawawin First Nation Band Members;

AND WHEREAS; Said By-law has met the Medical Services Branch requirements for "Mandatory Services";

AND WHEREAS; It is desirable that Chemawawin First Nation as a Self Governing people have control and administration of their own health and related services.

/2

A quorum for this Band
Pour cette bande le quorum est

consists of
fixé à _____

Council Members.
Membres du Conseil.

Alpheus Bran (Chief – Chef)
Roderick Beaulieu (Councillor – Conseiller)
Richard Beaulieu (Councillor – Conseiller)
_____ (Councillor – Conseiller)
_____ (Councillor – Conseiller)
_____ (Councillor – Conseiller)
_____ (Councillor – Conseiller)
_____ (Councillor – Conseiller)
_____ (Councillor – Conseiller)
_____ (Councillor – Conseiller)
_____ (Councillor – Conseiller)

FOR DEPARTMENTAL USE ONLY – RÉSERVÉ AU MINISTÈRE

1. Band Fund Code / Code du compte de bande	2. Computer Balances – Soldes d'ordinateur		3. Expenditure – Dépenses	4. Authority (Indian Act Section) / Autorité (Article de la Loi sur les Indiens	5. Source of Funds / Source des fonds
	A. Capital $	B. Revenue – Revenu $	$		☐ Capital ☐ Revenue / Revenu

6. Recommended – Recommendable	Approved – Approuvable
Date / Recommending Officer – Recommandé par	Date / Approving Officer – Approuvé par

IA 135 (9-85) 7530-21-023-4662

Canada

Indian and Northern Affairs Canada | Affaires indiennes et du Nord Canada

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Agency District	EASTERVILLE	Committed Engagé $
Province	MANITOBA	Current Revenue Balance Solde de revenue $
Place Nom de l'endroit	EASTERVILLE	
Date	24 (Day – Jour) January (Month – Mois) AD 19 90 (Year – Année)	Committed Engagé $

DO HEREBY RESOLVE:
DÉCIDE, PAR LES PRÉSENTES:

THEREFORE BE IT RESOLVED;

That the Chemawawin First Nation hereby request that the Government of Canada enacts a regulation under Section 73 of the Indian Act to allow the Chemawawin First Nation Health By-law to supersede the Indian Health Regulations, C.R.C. 1978, C 955 and the Indian Reserve Waste Disposal Regulations, C.R.C. 1978, C 960.

A quorum for this Band
Pour cette bande le quorum est

consists of
fixé à _____

Council Members.
Membres du Conseil.

Alphonse Bear (Chief – Chef)
Roderick George (Councillor – Conseiller)
Michael George Jr (Councillor – Conseiller)
(Councillor – Conseiller)
(Councillor – Conseiller)
(Councillor – Conseiller)
(Councillor – Conseiller)
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Date / Recommending Officer – Recommandé par	Date / Approving Officer – Approuvé par

IA 135 (9-85) 7530-21-023-4662

Canada

Chemawawin First Nation

FILE NO._____

FIRST NATION

HEALTH AUTHORITY

POLICY MANUAL

Easterville Manitoba R0C-0V0..Phone..329-2161

INTRODUCTION

Purpose

This manual contains the policies of the Board of Directors of the First Nation Health Authority. The manual has been prepared to:

- ensure consistency in the program
- provide a reference document for employees
- assist in orientation of new employees
- serve as a record of specific administrative decisions

Structure

The manual is divided into twenty-one major categories.

I Administrative Overview

II Treatment Services

III Family Health Care Program

IV Environmental/Occupational Health and Safety Program

V Alcohol and Drug Abuse Program

VI Community Health Promotion

VII Work Planning

VIII Referrals

IX Patient Consent

X Health Records

XI Drugs and Medical Supplies

XII Laboratory Prodedures

XIII Emergency Procedures

XIV X-Rays

XV Facilities and Equipment

XVI Finance

XVII Insurance

XVIII Program Evaluation

XIX Personnel Policies

XX Staff Job Descriptions

XXI Contract Services

Individual policies within each category have a number on the upper right hand corner of the page which indicates category number and individual policy number (eg. III - 10). Individual policies have been numbered in intervals to allow insertion of additional policies.

Revisions

This manual is subject to review and revision at the discretion of Chief and Council and on recommendation of the Board of Directors. If at any time you feel revisions are required, contact the Health Care Administrator who will advise the Board of Directors.

Responsibility for Manuals

The Health Care Administrator is responsible for ensuring that all copies of this manual are maintained up to date.

POLICY MANUAL TABLE OF CONTENTS

FIRST NATION
HEALTH AUTHORITY
POLICY MANUAL

Approved By: Number: I - 20

Date: Category: Administrative Overview

ADMINISTRATIVE AUTHORITY AND ORGANIZATIONAL STRUCTURE

Chief and Council of First Nation have asserted jurisdiction over health on-reserve through exercising their authorities under Section 81 of the Indian Act. Chief and Council have enacted a by-law to establish the First Nation Health Authority and to assign administrative responsibility for health services delivery on-reserve to the Board of Directors of the Health Authority. The Board of Directors is appointed by Chief and Council and is accountable to Chief and Council for fulfilling the assigned responsibilities. For this purpose, the Board of Directors has entered into a health program funding agreement with the Medical Services Branch of the Federal Department of Health and Welfare. Under the terms of the agreement the Board of Directors is accountable to the Federal Government for ensuring proper use of health program funds.

In order to meet its responsibilities, the Board of Directors has established the policies contained in this manual and has hired a Health Care Administrator to manage the day-to-day business of the Health Authority in accordance with Board policies. The Health Care Administrator occupies the senior staff position of the Health Authority and reports directly to the Board of Directors. All other staff of the Health Authority report to the Health Care Administrator.

Approved By:

Date:

Number: I - 10

Category: Administrative Overview

MISSION STATEMENT

The First Nation Health Authority has been established under the authority of Chief and Council to provide a locally controlled primary health care program which will be responsive to the health needs of residents.
The goal of the Health Authority is to contribute towards the development and maintenance of an improved level of health among community residents. Health is defined in the broad terms endorsed by the World Health Organization as a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity.

The First Nation Health Authority has been established with the recognition of several simple and straightforward conclusions regarding the health of Band members in 1988.

°The health status of First Nation members is generally poor in comparison to other Manitobans.

°Many of the prevalent health problems are preventable and could be ameliorated through enhancing preventative and health promotion components of the health program.

°Substantial improvements in health will require a strategy which addresses the interrelated factors of unemployment, poverty, low levels of education, poor housing, poor sanitation and poor nutrition.

°Many of the activities which will be required in order to achieve improvements in health do not fall strictly within the scope of a standard nursing station health program. Extensive community participation will be required.

These conclusions have been reformulated to provide the broad program objectives of the First Nation Health Authority.

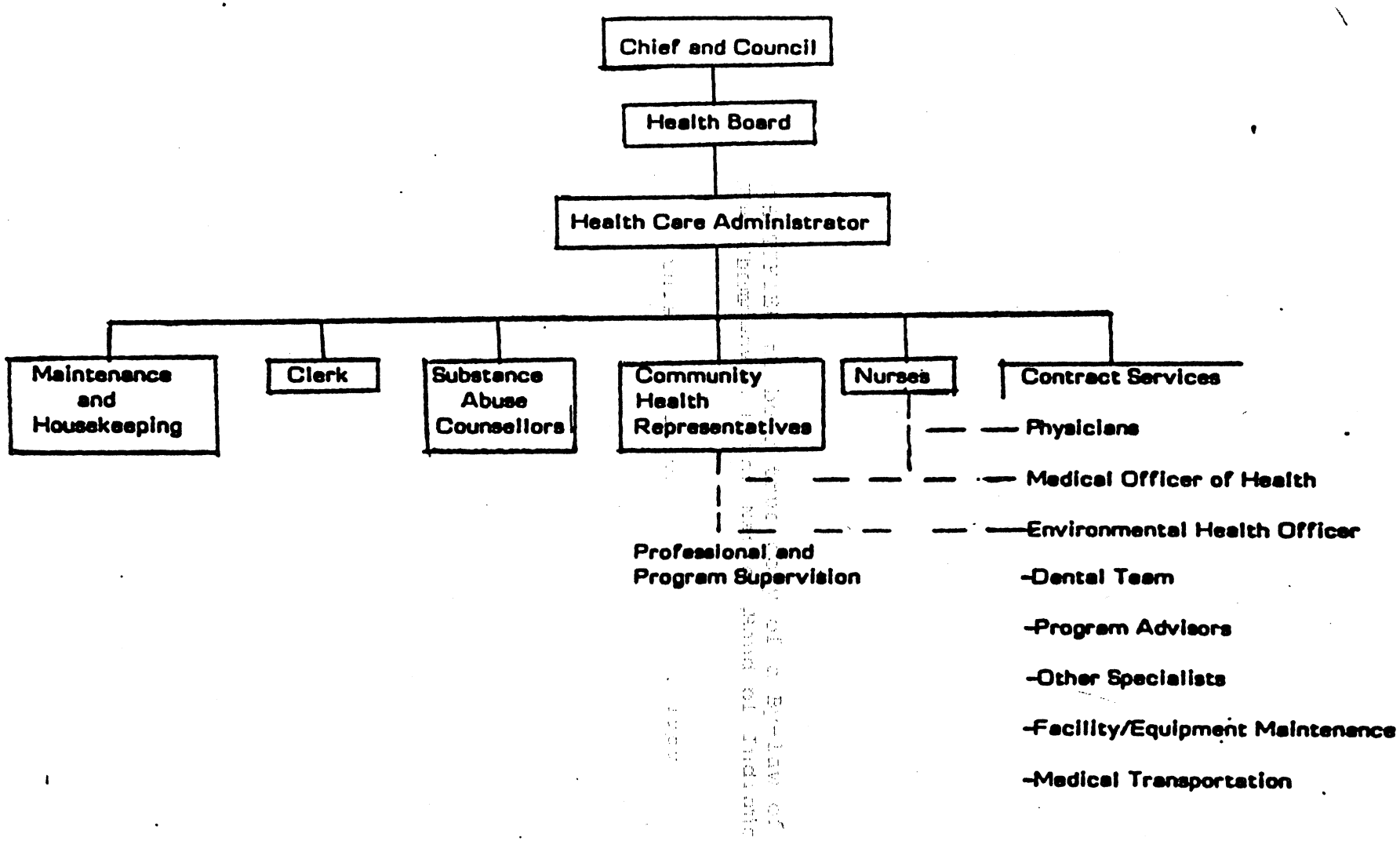
°To provide a proactive primary health care program emphasizing disease prevention and health promotion while ensuring access to high quality treatment services

°To enable and promote community participation in providing effective responses to health concerns

°To assist community residents in asserting control over factors affecting their health

°To contribute to the development of a multi-sectoral health management approach through advising Chief and Council on the formulation of healthy public policy

ORGANIZATION CHART
FIRST NATION
HEALTH AUTHORITY



CHEMAWAWIN FIRST NATION
BAND OF INDIANS

Easterville, Manitoba

By-law for the Establishment
of The Chemawawin First Nation Health Board
and OTHER RELATED MATTERS

CERTIFIED to be a true copy of a By-law of
The Chemawawin First Nation Band of Indians
passed by Chief and Council of the
Chemawawin First Nation Band of Indians
this day of , 1989

CHIEF ALPHEUS BRASS

CHEMAWAWIN FIRST NATION
HEALTH AUTHORITY BY-LAW

Preamble

WHEREAS the Chemawawin First Nation peoples have a right to health services at an adequate and proper level to meet their health requirements;

AND WHEREAS the Chemawawin First Nation entered into solemn Treaty arrangements with Her Majesty's Government of the Dominion of Canada by adhesion to Treaty Number 5;

AND WHEREAS the Chemawawin First Nation did not, through said Treaty give up their authority to be a self-governing people;

AND WHEREAS the Chief and Council of Chemawawin First Nation desires by this by-law to take over responsibility for the delivery of health and related services and programs;

AND WHEREAS Section 81 (1) (a), (d), (f), (g), (h), (j), (l), (q), and (r) of the Indian Act R.S.C. 1970 Ch. 1 - 6 as amended empowers the Chemawawin First Nation to make by-laws inter alia;

(a) To provide for the health of residents on the reserve and to prevent the spreading of contagious and infectious diseases;

(d) The prevention of disorderly conduct and nuisances;

(f) the construction and maintenance of water courses, roads, bridges, ditches, fences and other local works;

(g) The dividing of the reserve or a portion thereof into zones and prohibition of the construction of buildings or the carrying on of any class of business, trade or calling in any such zone;

(h) The regulation of the construction, repair and use of buildings, whether owned by the Band or by individual members of the Band;

(j) The destruction and control of noxious weeds;

(l) The construction and regulation of the use of public wells, cisterns, reservoirs and other water supplies;

(q) With respect to any matter arising out of or ancillary to the exercise of powers under this section;

(r) The imposition on summary conviction of a fine not exceeding one thousand dollars or imprisonment for a term not exceeding thirty days, or both, for violation of a by-law made under this section.

AND WHEREAS Section 36 of the Constitution Act, 1982 provides that without altering legislative authority of Parliament or of the Provincial Legislatures, or the rights of any of them with respect to the exercise of their legislative authority, Canada and Manitoba are committed to:

a) Promoting equal opportunities for the well being of Canadians;

b) Furthering economic development to reduce disparity in opportunities; and

c) Providing essential public services of reasonable quality to all Canadians.

AND WHEREAS the Chemawawin First Nation defines health in the same terms as endorsed by the World Health Organization as a state of complete physical, mental and social well being and not merely the absence of disease or infirmity.

AND WHEREAS the health conditions of the Chemawawin First Nation Indian Reserve cannot be significantly improved without Indian involvement in and control of local health care services.

AND WHEREAS the Chemawawin First Nation peoples desire their Chief and Council to create, maintain and operate a local health authority on their reserves.

AND WHEREAS pursuant to Section 73 of the Indian Act, the Government of Canada has enacted certain regulations respecting health and waste disposal.

AND WHEREAS the Chief and Council has by Band Council Resolution has requested the Minister to exempt Chemawawin Indian Band from said regulations and enable this by-law to supercede said regulations.

AND WHEREAS the Chemawawin First Nation was not a party to the Memorandum of Agreement entered into in 1964 between the Medical Services Branch and Manitoba Health and is therefore not bound by that Agreement.

AND WHEREAS nothing in this by-law shall alter, diminish, abrogate, derogate or breach the Treaty and or Aboriginal rights of the Chemawawin Band of Indians or its members.

AND WHEREAS further, nothing in this by-law shall alter, diminish, abrogate, derogate or breach the Treaty status of the Chemawawin Band of Indians or its members under Treaty Number 5 with Her Majesty's Government of Canada, nor shall it be interpreted or construed to do so.

BE IT ENACTED AND THEREFORE IT IS HEREBY ENACTED as a By-Law of the Council of the Chemawawin First Nation herein called the "Band Council" as follows:

Council Authorized to Obtain Agreements for Local and Regional Health and Related Services

1. The Band Council is hereby authorized to enter into such agreements and declarations as in its sole discretion it deems appropriate, to create, maintain and operate a Chemawawin First Nation Health Board (hereinafter referred to as the "Board") to serve the community health needs of the Chemawawin First Nation.

Establishment of Chemawawin First Nation Health Board

2. The Band Council hereby enacts and it is hereby enacted and established that there shall be a Chemawawin First Nation Health Board hereinafter referred to as the "Board".

3. The community health service needs of residents on-Reserve shall be administered, delivered and maintained by the Board. The Board shall be guided

initially by the Chemawawin First Nation Health Policy Manual (hereby incorporated by reference to this by-law and attached hereto as Appendix "A"). The Board shall in the future make recommendations to the Band Council for the revision of the policies set out in the said manual as changing conditions require.

4. The Band Council shall appoint the Chemawawin Health Board and said Board shall be responsible and accountable to the Band Council.

a) A Director's term of office, subject to future Band by-laws, shall be for a four year term or until a successor is appointed by Chief and Council.

b) Vacation of Office. The office of Director shall be vacated automatically:

i) if by notice in writing to the Board he resigns his office;

ii) if he dies;

iii) if he misses three consecutive Board meetings without a reasonable excuse;

iv) if he is found to be of unsound mind;

v) if he is dismissed for "just cause" by the Band Council.

c) The Band Council has authority to dismiss Board members for "just cause". Change in the composition of the Chief and Council shall not be "just cause" within the meaning of this clause. Such matters as serious misconduct, breach of confidentiality, failure to responsibly perform the duties of a Board member, missing meetings too frequently, or conviction for a serious criminal offence may fall within the definition of "just cause".

d) The Directors shall establish operating procedures of the Board and dealing, inter alia, with such matters as meetings, duties of Directors, the establishment of Board Committees to monitor, evaluate and assess the various programs that are delivered by the Board.

e) The Directors shall meet not less than 10 times per year. The Directors are empowered to include in their operating procedures a provision for meetings by telephone conference where circumstances warrant.

Board of Directors

5. a) The Board shall consist of seven members, five of whom shall be voting members and at least four of whom must be members of the Chemawawin Indian Band.

b) In appointing the Directors, Chief and Council shall be guided by the need to provide representation on the Board from the following elements of the Chemawawin First Nation Community:

* Representation from the Chemawawin First Nations elders;
* Representation from youth (ages 18 to 30)
* Representation by persons knowledgeable on health issues of the community.

c) There shall be representation by a Band Councillor for the Chemawawin First Nation with responsibility for the Health Portfolio. Said Councillor shall sit as an ex officio member and shall have no vote at board meetings.

d) The Community Council for the Community of Easterville may designate a Board member and the Chief and Council may appoint such person as a member of the board.

e) The Board is hereby authorized to select a chairman from amongst their midst and to appoint such other officers as they may see fit. The chairman shall not have a vote except in the event of a tie vote in which case the chairman shall cast the deciding vote.

f) Sitting Board members are eligible for reappointment at the expiry of their term.

g) Persons employed by the Board shall not be eligible for Board membership.

h) A quorum of the board shall be four, at least three of whom must be voting members.

Health Care Administrator to Attend All Board Meetings

6. The Health Care Administrator selected by the Board shall have, as part of his job description, an obligation to attend all meetings of the Chemawawin First Nations Health Board.

Confidentiality of Client/Patient Records

7(1) Subject to this by-law, client/patient records made under this by-law and the Chemawawin Health Policy are confidential and no person shall disclose or communicate information from the record in any form to any person except:

a) to the Chemawawin Health Care Administrator, or to a person employed, retained or consulted by said Health Care Administrator in the course of administering or enforcing any provision of this by-law or the Chemawawin Health Care Policy;

b) to the client/patient in question provided that release of the information to the client/patient has been approved by the Chemawawin Health Care Administrator;

7(2) A client/patient of the Chemawawin Health Authority is entitled to be given access to:

i) his or her own records; and

ii) the record of a child who is in the adult's legal care subject to the exceptions contained in paragraph 7(3) herein;

7(3) The Chemawawin Health Care Administrator may refuse to give a person access to all or any part of a record referred to in 7(2) where:

a) There are reasonable grounds to believe that disclosure of all or part of the record might result in physical or serious psychological harm to that person;

b) That part of the record discloses the identity of a person who is not employed by the Chemawawin Health Authority and who has supplied information in confidence to the Chemawawin Health Authority for any purpose relating to the administration or enforcement of this by-law or the Chemawawin Health Policy;

and the Chemawawin Health Care Administrator shall notify the person in writing of the reasons for refusing access to all or any part of his or her record or the record of a child in his or her care.

7(4) It shall be stipulated in every contract of employment that the Board enters into that employees are undertaking to protect and honour the special relationship and confidentiality that exists between the Health Board and its clients/patients. It shall be further stipulated that breach of such confidentiality may be grounds for dismissal.

7(5) It shall be the duty of every Director of the Board to comply with the confidentiality provisions of this by-law and should a Board member breach said confidentiality provisions it shall be grounds for the dismissal of that Board member from his position by the Band Council.

The Board May Negotiate Agreements

8(1) The Band Council hereby authorizes the Board to negotiate agreements with other Swampy Cree Tribal Bands, the Federal Government, the Provincial Government, public health services agencies, or other private health services agencies, or other such agencies pursuant to the Chemawawin Health Policy Manual for the delivery of regional or community health services to residents including, inter alia, the provision of or construction of health services facilities, the provision of health services staff and personnel including, inter alia, physicians, community health representatives, dentists, dental assistants, dental therapists, nurses, midwives, traditional Indian healers, medical officers of health, environmental health officer, and other necessary personnel;

8(2) Without restricting the generality of the foregoing, the Band Council hereby authorizes the Board to negotiate agreements for the maintenance and construction of nursing stations or other health care delivery facilities.

8(3) All such agreements shall be brought to the Band Council for approval and ratification.

Responsibilities of the Board

9(1) The Board shall be responsible for the overall administration, maintenance and delivery of

health services in the community and without restricting the generality of the foregoing may:

a) Develop operating procedures for the Board;

b) Recommend administrative, personnel, financial, and other policies;

c) Receive and approve budget;

d) Subject to the approval and ratification of the Band Council, borrow and spend money and acquire, dispose of and manage all forms of personal property;

e) Manage such real property as the Band Council may direct;

f) Review and approve the Annual Report;

g) Provide an Annual Report to the Chief and Council and consult from time to time with Chief and Council on the health needs of the community;

h) Hire and dismiss a qualified Health Care Administrator;

i) Advise the Band Council on health and health related policy matters;

j) Ensure that policies and procedures are in place to maintain the traditional confidentiality of medical records.

10. The Board may enter into agreements for the retention of a qualified Health Care Administrator who shall be responsible and accountable directly to the Board and who shall be the senior health services staff officer.

11. The Board shall have the power to maintain, control, and manage the affairs of the various health and related activities of the Chemawawin First Nation, and the power to disburse funds up to the amount of the budget approved by the Band Council and where necessary, any parties to any agreements made pursuant to this by-law and to disburse any other grants, fees, donations or other monies received by the Authority in the course of operating their programs and activities pursuant to the Chemawawin Health Policy Manual.

Duties of Health Care Administrator

12(1) The Board may determine from time to time the duties and responsibilities of the qualified health care administrator and without restricting the generality of the foregoing the qualified health care administrator shall be responsible for:

a) organizing and managing the day to day business of the Health Authority;

b) establishing procedures to implement policies contained in the Chemawawin Health Policy Manual;

c) personnel administration and supervision of health services and staff including the power to hire and fire, subject always to such policy as to appeals or grievances as may be established by the Board;

d) financial administration;

e) program supervision;

f) liaison with other agencies;

g) managing all arrangements contracted for with others;

h) reporting to the Board on all the above mentioned matters in such form and on such schedules as the Board may from time to time determine.

Staffing and Personnel

13. The Board may determine from time to time the duties and responsibilities and the number of staff and personnel of the Board and without restricting the generality of the foregoing including, inter alia, dental assistants, dental therapists, nurses, midwives, traditional Indian healers, medical officers of health, environmental health officers, clerks, and other necessary personnel.

14. The Board may recognize persons who act as traditional Indian healers and may provide for a method of any remuneration or any compensation to the traditional Indian healers for such services.

Program and Services

15(1) The Chemawawin First Nation is not a party to the Memorandum of Agreement between the Federal Government of Canada and the Province of Manitoba entered into in 1964. The Chemawawin First Nation, Band Council, and Board is not bound by the said 1964 Agreement.

15(2) The Board is hereby mandated, subject to negotiations involving Canada, the Band Council, the Community Council of Easterville and the Province of Manitoba to establish a nursing station on the Chemawawin First Nation Reserve Lands within twelve months of the enactment of this by-law.

15(3) The Board shall administer, manage, maintain and deliver, in accordance with the Health Transfer Agreement between the Minister of National Health and Welfare and the Chemawawin Band, the following health services and programs and it is hereby enacted that at a minimum specific Provincial standards relating to such programs shall apply until such time as there may be an Agreement to the contrary between the Minister of Health and Welfare for Canada and the Chemawawin Band.

a) Those treatment services contained in Health and Welfare Canada's Health Program Transfer Handbook dated September 28, 1989 and any amendments thereto;

b) Communicable disease control;

c) Occupational and environmental health and safety;

d) Emergency health planning.

16. The Board shall administer and maintain such other local health services as are determined by the Band Council to be required to be administered, maintained, and delivered to members of the Chemawawin First Nation.

Enforcement and Penalties

17. Insofar as they are not inconsistent with this by-law or any future by-law, specific provincial laws and regulations relating to the matters mentioned in paragraphs 15(3)(a), (b), (c), and (d) are hereby

incorporated as part of this by-law and may be enforced as part of this by-law, until such time as the Band Council may otherwise agree with the Minister of Health and Welfare for Canada.

18(1) The Board may, from time to time, recommend to the Chief and Council:

a) Amendments to this by-law;

b) The enactment of further by-laws to create or give effect to programs required for the health and well being of members of the Chemawawin First Nation;

c) Other measures that may be required to enable the Board to carry out its duties and responsibilities.

19. The Board is hereby authorized to take any action necessary to ensure this by-law or policy established thereunder is complied with.

20. The Board may consult with the Band Council when enforcing this by-law or ensuring compliance with this by-law.

21. This by-law shall be enforced by Band Constables or any other Peace Officers serving the Chemawawin Band or by inspectors employed or designated by the Board.

22. Every individual, person or corporate body shall comply with this by-law and the laws and regulations referred to in paragraph 17.

23. A violation of this by-law that continues for more than one day constitutes a separate offence for each day during which it continues.

24. Any individual, person or corporate body who violates any of the provisions of this by-law shall be guilty of an offence, and shall be liable on a summary conviction to a fine not exceeding $1,000.00 or imprisonment for a term not exceeding 30 days, or to both a fine and imprisonment, for each violation.

Interpretation

25. In this by-law, the masculine includes the feminine, the feminine the masculine and the singular includes the plural and the plural the singular as the context requires.

Severability

26. In the event that a Court of competent jurisdiction or other body with jurisdiction determines that any provision herein is unlawful or beyond the jurisdiction of the Chief and Council, and/or the Government of Canada, said provision shall be severable from this by-law and the remainder of the terms of the by-law and any regulations thereunder or future by-law shall remain in full force and effect.

For the Protection of Directors and Officers

27. No Director or Officer of the Board shall be liable for:

a) the acts, receipts, neglects or defaults of any other director or officer or employee;

b) for joining in any receipt or act for conformity;

c) for any loss, damage or expense happening to the Board through the insufficiency or deficiency to title to any property acquired for or on behalf of the Board;

d) for the insufficiency or deficiency of any security upon which any of the monies of the Board are placed or invested;

e) for any loss or damage arising from the bankruptcy, insolvency or tortious act of any person, firm or corporation with which any monies, securities or effects shall be deposited or lodged;

f) for any loss, conversion, misapplication or misappropriation of, or any damage resulting from any dealings with any monies, securities, or other assets belonging to the Board;

g) for any other loss, damage or misfortune whatever;

unless the above shall happen by his failure to exercise the powers and to discharge the duties of his office of trust honestly in good faith and in the best

interests of the Board, and to exercise the degree of care, diligence and skill that a reasonable prudent person would exercise in comparable circumstances.

Indemnities to Directors and Officers

28. Subject to the provisions of this by-law, every Director and Officer of the Board, his heirs, executors, administrators, and other legal personal representatives and persons acting on instruction of the Board shall be indemnified by the Board for:

a) any liabilities, costs, charges and expenses that he sustains or incurs in respect of any action, suit or proceeding that is proposed or commenced against him in respect of the bona fide execution of the duties of his office; and

b) all other charges, expenses which he sustains or incurs in respect of the affairs of the Board.

DONE AND PASSED by Chief and Council in Council assembled this day of , A.D., 1989.

THE CHEMAWAWIN BAND OF INDIANS

Per:

_____ _____

Chief

_____ _____

_____ _____

_____ _____

(A QUORUM FOR THIS BAND CONSISTS OF FOUR (4) COUNCIL MEMBERS)

Approved By:

Number: 1 - 30

Date:

Category: Administrative Overview

COMMUNITY HEALTH PLAN/PROGRAM OUTLINE

The Chemawawin First Nation Community Health Plan and program outline (June 1989) shall be basis for negotiation and implementation of the Health Authority program.

CHEMAWAWIN FIRST NATION

COMMUNITY HEALTH PLAN

prepared under the direction of

CHEMAWAWIN FIRST NATION HEALTH AUTHORITY

BOARD OF DIRECTORS

EASTERVILLE, MANITOBA

JUNE, 1989

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APPENDICES

Preface

Over the past three decades, Chemawawin First Nation has endured much adversity. The original community of Chemawawin, which was situated in some of the finest wildlife habitat in North America, was flooded in 1964 as a result of the Grand Rapids hydroelectric project. The people of Chemawawin were relocated to a barren stony ridge on the shore of the Cedar Lake impoundment. Here, the people of Chemawawin have struggled to rebuild their community in a damaged and relatively unproductive environment.

The present value of resource losses suffered by Chemawawin as a result of the relocation is estimated to be well in excess of $20 million. Less tangible impacts to individual and community health and well-being defy quantification. In large measure, Chemawawin has borne these impacts without compensation. The Chemawawin relocation has become infamous as an example of failure to manage social impacts, and of callousness on the parts of both federal and provincial governments.

In the same year that the old community of Chemawawin was flooded, federal and provincial officials once again sat down together to make decisions which would have great consequences for the people of Chemawawin. This time, the people of Chemawawin had even less of an opportunity to voice their concerns than they'd had in the relocation decision. Government bureaucrats decided amongst themselves that henceforth the Province of Manitoba would be responsible for delivery of community health services to Chemawawin First Nation. Thus, at a time when the people of Chemawawin were faced with a situation which would obviously greatly impact on their health, the federal government unilaterally abdicated it's responsibility to ensure adequate health

care. The people of Chemawawin were locked into a health care delivery system which offered lower service levels and fewer opportunities for community participation than were available to other Indian communities in Manitoba. Chemawawin was denied access to federal funding for local control of Community Health Representative and local medical transportation programs, neither of which have any counterpart within the provincial system. All of this transpired over a period when a responsive community based health program might greatly have reduced the health problems associated with relocation of the community.

The events of 1964 and their aftermath are history. This document, Chemawawin First Nation's plan for community health development, is concerned with the present and the future. We intend to establish a First Nation controlled health program which will address community health needs. We have had enough experience of the consequences of decisions being made for us.

CHEMAWAWIN FIRST NATION

COMMUNITY HEALTH PLAN

1.0 GOALS

Chemawawin First Nation's goal in entering the health program transfer process is to establish a First Nation controlled primary health care program which will be responsive to the health needs of residents of the reserve community of Easterville. The central goal of the transferred health program will be to contribute towards the development and maintenance of an improved level of health among community residents. Health is defined in the broad terms endorsed by the World Health Organization as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

2.0 HEALTH NEEDS

Statistics compiled by the Manitoba Health Services Commission indicate that the health of Chemawawin First Nation members is generally poor in comparison to other Manitobans. For example, hospitalization rates (see Table 1)* for Band members are on average 3.3 times higher than for other Manitobans. Admission rates for several specific diagnostic categories are much further out-of-line with those for other Manitobans.

°infectious and parasitic diseases	8.0 times higher
°skin and subcutaneous diseases	7.0 times higher
°respiratory system diseases	6.4 times higher
°injuries and poisonings	4.0 times higher
°obstetrical conditions	5.7 times higher

*See Appendix A for health needs tables.

at the expense of reducing the availablity or quality of treatment services. Treatment, disease prevention and health promotion are all priority needs.

3.0 HEALTH PROGRAM PRIORITIES

Health needs research has led to several simple and straightforward conclusions regarding the health of Band members in 1989.

- °The health status of Chemawawin First Nation members is generally poor in comparison to other Manitobans.
- °Many of the prevalent health problems are preventable and could be addressed through enhancing preventative and health promotion components of the health program.
- °Substantial improvements in health will require a strategy which addresses the interrelated factors of employment, education, housing, sanitation and nutrition.
- °Many of the activities which will be required in order to achieve improvement in health do not fall strictly within the scope of a standard nursing station health program. Extensive community participation will be required.

Based on these conclusions, the following broad program priorities have been identified:

- °To provide a proactive primary health care program emphasizing disease prevention and health promotion while ensuring access to high quality treatment services.

°To enable and promote community participation in providing effective responses to health concerns.

°To assist community residents in asserting control over factors affecting their health.

°To contribute to the development of a multi-sectoral health management approach through advising Chief and Council on the formulation of healthy public policy.

Underlying these priorities is a philosophy of primary health care which recognizes the individual, the family and the community as the foundation of the health care system.

4.0 STRATEGY

4.1 The Communities of Easterville

As noted earlier, the Manitoba Department of Health has assumed responsibility for delivery of community health services to Chemawawin First Nation. These services are provided from a nursing station location in the adjacent non-status community of Easterville, and from the district office in The Pas.

History and relocation have made Easterville an unusual community. Driving into Easterville, one encounters what appears to be a single town of about 140 wood frame houses. However, Easterville is two communities. About 70% of the residents are Chemawawin First Nation members residing on-reserve. The remaining 30% of residents are on crown land and are predominantly non-status Indians. Among other thing, this means that there are two elected local governments:

a Mayor and Council under provincial jurisdiction for the non-status community; and a Chief and Council under federal jurisdiction for the Chemawawin First Nation community. Community leaders have learned over the years that these legal, political and social realities of Easterville cannot be ignored. Many difficulties have been encountered with attempts at sharing educational, health sanitation and other community services.

The situation described above is in flux. As a result of the 1985 changes to The Indian Act (Bill C-31), almost all of the non-status residents of Easterville are expected to be reinstated as status members of Chemawawin First Nation. Moreover, some 70% of the Bill C-31 reinstatees are expected to seek residence on-reserve. By 1995 Chemawawin First Nation is expected to have doubled in size to a membership of about 1000 people.

4.2 Chemawawin First Nation's Position on Health Program Control

For many years, Chemawawin First Nation has sought a greater role in health service delivery. Experience has led us to formulate a practical and fair position in the area of health services.

Our position is that Indian people were not party to the 1964 federal/provincial Memorandum of Agreement (MOA) on health services delivery, and are not bound by it. We have received a legal opinion to this effect. We have also been advised that under Section 81 of the Indian Act the Bands have the authority to enact by-laws to provide for

the health of residents on-reserve. By exercising this authority the Band could assert their jurisdiction over health, thereby repudiating the 1964 MOA and replacing it with their own by-law governing the delivery of health services.

We are seeking a health program transfer agreement with the federal government. We recognize the federal government may wish to recover from the province resources which are currently committed to servicing our Band. However, we caution the federal government that provincial committments will not be adequate. Current service levels are below recognized standards. Provincial committments would not include the costs of local health management. We will want to negotiate transfer agreements which provide for:

1. Service levels which meet Booz-Allan and Hamilton standards
   - 1 nurse per 500 population
   - 1 community health representative per 500 population
   - 12 days per year visiting physician services per 120 population
2. All supplementary resources promised in current federal health program trnasfer policy, including:
   - health management funding (salary, benefits, training and travel of a health administrator as well as honoraria training costs and other expenses of health committee or board members)
   - funds equal to all program costs associated with district, regional or head office activities related to the delivery of a reasonable level of health services
   - basic overhead and office costs
   - annual audit costs

- facility operating costs
- funds to cover the costs of developing and implementing a program evaluation process

The health program we have designed has been planned to provide for the health needs of Chemawawin First Nation Members. While it appears that in time, virtually all Easterville residents will be First Nation members, we cannot ignore the current legal and political realities. The Manitoba Department of Health retains a responsibility to provide for the health needs of those Easterville residents who are not represented by Chief and Council. How that responsibility is fullfilled is the concern of the Easterville Mayor and Council and the Manitoba Department of Health.

There are no health facilities on-reserve at Easterville. The provincial nursing station is located on crown land. As a result of the lobbying efforts of Cheamawawin First Nation leaders, the Department of Health has scheduled replacement of the presently dilapitated facilty. Given the expected impacts of Bill C-31 reinstatements, it is apparent that any new facility, regardless of funding arrangements, should be located on-reserve and designed to serve the needs of the projected First Nation membership.

4.3 Health Program Strategy

Community health services manuals of the Medical Services Branch (MSB) of the federal government outline a health program which in concept

concept is sound. There is a strong prevention and promotion orientation which would appear to address identified health needs in Easterville. The federal manuals also appear to provide a more coherent and comprehensive framework for service delivery than do the program documents currently in use in provincial nursing stations. Nevertheless, Chemawawin leaders are aware that difficulties have been encountered in implementing the MSB program in other communities. Experience in other communities has been examined and a strategy developed for improved implemention of a program broadly based on the MSB model. Our stragegy for implemention has several components:

°Community Ownership - at the most fundamental level we will change who implements the program by establishing the Chemawawin First Nation Health Authority under Band by-law and through participation in the Swampy Cree Tribal District Health Centre;

°Family Health Care Programming - at philosophical and practical levels we will change the program orientation towards proactive care and efficient team delivery by instituting family oriented health care programming and work planning as the basis for ensuring coordinated delivery of services responsive to health needs;

°Health Promotion - at the levels of individual and community we will change attitudes about health and health care through promoting self-care and self-reliance and community participation in responding effectively to health concerns.

A more detailed discussion of management structure, staffing and program areas follows.

5.0 CHEMAWAWIN FIRST NATION HEALTH AUTHORITY

At the community level, the foundation for local control and accountability will be laid through the establishment of Chemawawin First Nation Health Authority---an agency of the First Nation established by Band by-law* for the sole purpose of providing for the health needs of the membership.

A six member Board of Directors of the Health Authority has been appointed by Chief and Council. Board members are appointed for a four year term and are selected to provide representation from Chemawawin First Nation elders, youth, persons knowledgeable of health issues in the community and the First Nation Health Portfolio Councillor.

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*Member First Nations of Swampy Cree Tribal Council are working cooperatively on the by-law development process. While each First Nation will pass its own by-law, Tribal Council Members are presently monitoring progress of an initial by-law developed by Mathias Colomb First Nation.

The Mathias Colomb First Nation Health Authority By-Law was disallowed by the Minister of Indian Affairs on technical grounds April 7, 1989. Chief and Council are confident that the technical issues can be resolved and are proceeding to redraft the by-law. Until such time as by-laws are approved, the existing legal and administrative framework remains in effect.

As a group, Board members are the trustees of the Health Authority and responsible to the First Nation Council and membership. Functional areas of responsibility of the Board of Directors include:

°Organizational Continuity - maintaining the continuous orderly and efficient functioning of the Health Authority through actions to ensure that a full complement of competent and committed people are hired or appointed to carry out the work of the organization at all times;

°Public Relations - fostering public support and participation in the work of the Health Authority through; ensuring the membership is informed of the purpose, goals, structure and functions of the health program; approving and issuing an annual public report and audited financial statement on Health Authority operations; and hosting an annual public meeting to review the report of the Health Authority;

°Funding - ensuring that the Health Authority has sufficient funds to operate at all times through developing with staff an annual budget based on realistic plans, approving the budget and monitoring expenditures;

°Policy Setting - developing policy and approving procedural guidelines in the areas of administration, personnel, finance, provision of services, program planning, facilities and other areas;

°Program Planning - developing and approving goals and objectives annually and monitoring plan implementation;

°Advisory - advising Chief and Council on health and health related policy matters.

In order to provide a framework for implementation and operation of the health program the Board of Directors is preparing a Health Authority Policy and Administration Manual. The manual is being prepared to: ensure consistency in the program; provide a reference document for employees; assist in orientation of new employees; and serve as a record of specific administrative decisions. The manual will be subject to review and revision at the discretion of the Board. In draft format the manual encompasses twenty-one major categories.

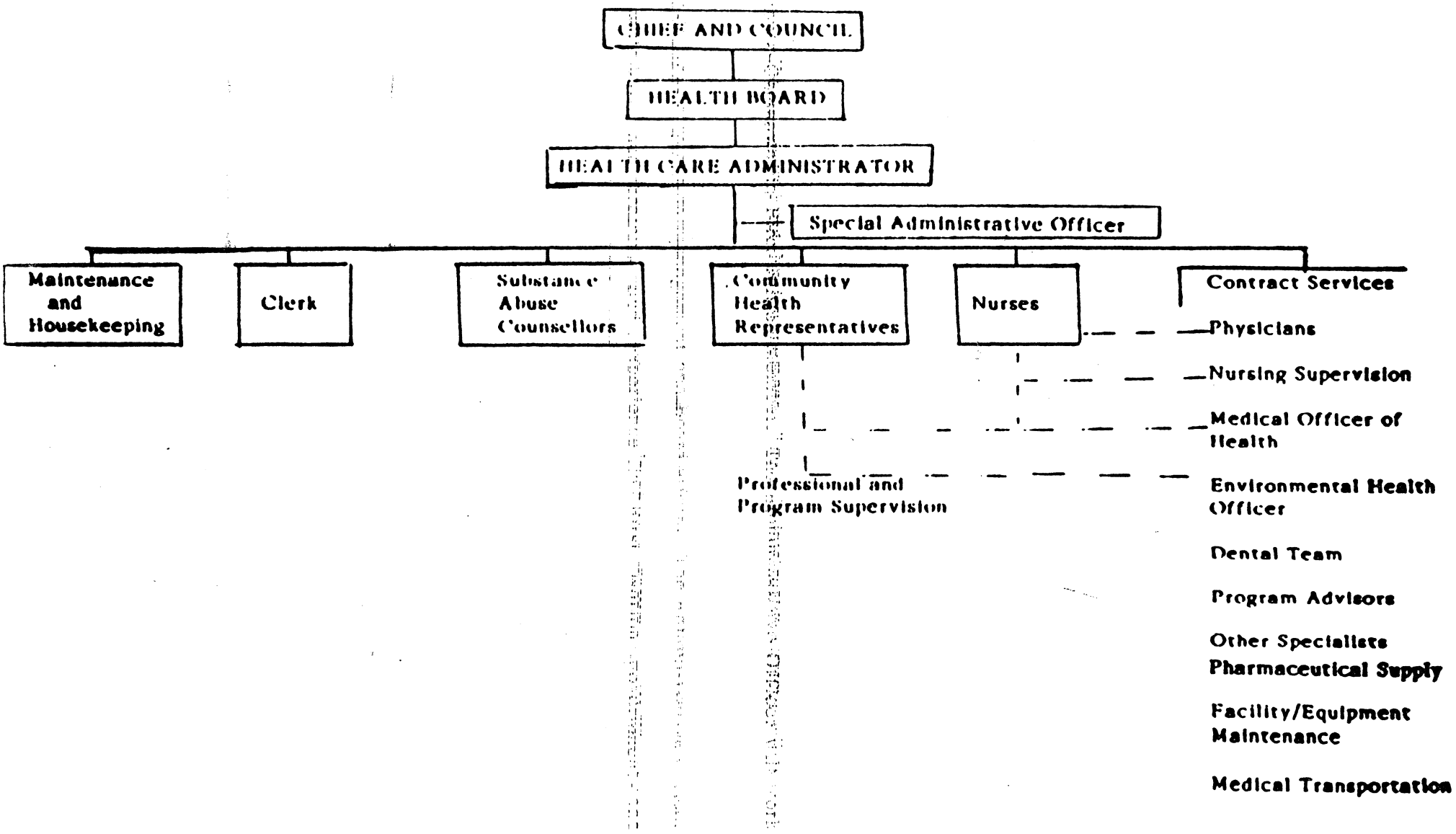
Administrative Overview
Treatment Services
Family Health Care
Environmental Health
Substance Abuse
Health Promotion
Work Planning
Referral
Patient Consent
Health Records
Drugs and Medical Supplies
Laboratory Procedures
Emergency Procedures
X-Rays
Facilities and Equipment
Finance
Program Evaluation
Personnel Policies
Staff Job Descriptions
Contract Services
Insurance

6.0 HEALTH AUTHORITY STAFFING

6.1 Health Care Administrator

The Board of Directors will hire a Health Care Administrator with a certificate in health care administration and experience in primary health care program management to occupy the senior staff position of the Health Authority.

ORGANIZATION CHART
CHEMAWAWIN FIRST NAITON
HEALTH AUTHORITY



The Administrator will be the primary advisor to the Board and will report directly to the Board. All other staff of the Health Authority will report to the Administrator.

The Administrator will be responsible for establishing procedures to implement the policies of the Board and for organizing and managing day-to-day operations of the health Authority. Major areas of responsibility will include: direction of the program planning process; personnel administration; financial administration; program supervision; contracts administration; and liaison with outside agencies.

6.2 Special Administrative Officer

A special two year term position of Administrative Officer will be staffed by a Chemawawin First Nation member. The Administrative Officer will work directly with the Health Care Administrator as assistant and apprentice in all areas of program management and Board affairs. The Administrative Officer will have had training and experience in First Nation government and administration and will be expected to complete a certificate program in health care administration during the two year term of employment. At the end of the term it is expected that the Administrative Officer will be promoted to the position of Health Care Administrator.

The Board recognizes that the long term success of the Health Authority will be strongly influenced by the lessons learned and the decisions made during the initial years of operation. The term position of Administrative Officer has been developed to serve several purposes during this formative period:

°to provide an opportunity for a First Nation member to develop management skills appropriate to the requirements of the Health Authority through combining formal accredited training with apprenticeship and work experience in implementation of the community health program;

°to provide an avenue for ensuring that a fully qualified First Nation member will assume the senior staff position of the Health Authority within a reasonable time frame;

°to provide the Board and the Health Care Administrator with an assistant who is knowledgeable in community affairs, during the first few years of operation when the workload will be particularly heavy.

6.3 Nurses

The Health Authority will employ two resident registered nurses with training in community health and clinical skills. Nurses will participate with other members of the community health care team in delivery of a proactive primary health care program to residents of Easterville. The nurses primary areas of responsibility will be to assume lead roles in delivery of comprehensive family health care services to assigned client families/households, and to work in conjunction with the other staff nurse and visiting or supervising physicians in providing primary treatment and referral services.

Until such time as legal and liability issues associated with expanded nursing practice in Manitoba are resolved, nurses will be employed under the Interchange Canada Program and arrangements will be made with Medical Services Branch to meet the interchange program requirements for professional nursing supervision. Nurses will report directly to the Health Care Administrator.

6.4 Community Health Representatives

The Health Authority will employ two First Nation members as community health representatives (CHR's). CHR's will have trained through the Medical Services Branch CHR program or a comparable program and will be fluent in Cree and English and knowledgeable of the community socio-cultural system and health needs. CHR's will report directly to the Health Care Administrator.

CHR's will participate in team delivery of family health care services under the lead direction of responsible nurses and provide support to nurses and physicians in provision of treatment services. CHR's will assume lead responsibility for delivery of comprehensive environmental/occupational health and safety surveillance and promotion services. CHR's will also be in charge of co-ordinating cultural awareness and community orientation training for all new Health Authority employees.

6.5 Substance Abuse Counsellors

The Health Authority will employ two First Nation members as substance abuse counsellors. Counsellors will have trained through the National Native Alcohol and Drug Abuse Program and will be fluent in Cree and English and knowledgeable of the community socio-cultural system and health needs. Counsellors will report directly to the Health Care Administrator.

Counsellors will assume the lead role in delivery of substance abuse prevention, counselling, public awareness and referral services and will participate in team delivery of family health care services under the lead direction of responsible nurses.

6.6 Behavioral Health Educator

In the third year of operation the Health Authority will staff the position of Behavioral Health Educator through reallocation of resources from the two year term position of Special Administrative Officer. The position will be staffed by an individual with training in applied behavioral sciences and knowledge of native community health needs. The Behavioral Health Educator will be responsible for working with the community health team in planning, developing and implementing a program to mobilize community resources to address mental health needs.

6.7 Extended Care Co-ordinator

Chemawawin First Nation members are deeply committed to the development of facilities and programs to provide for the well-being of the elderly and disabled in the community. The membership is also keenly aware of the disparity between reserve communities and other communities with respect to services and funding available for extended care. The goal of the First Nation is to establish comprehensive home care services provided under the direction of professional nursing staff of the Health Authority.

In planning to fulfill it's role and commitments with respect to integrated extended care needs, the Board of Directors have identified the requirement to staff a third nursing position within three years. The third nursing position will be dedicated to providing coordinated health care services to the elderly and disabled and will work in conjunction with both Health Authority and staff and community volunteers. The nurse will report directly to the Health Care Administrator.

6.8 Clerk

The Health Authority will employ a First Nation member as clerk and office manager for the health program. The clerk will be fluent in Cree and English and have well developed secretarial and office management skills. The clerk will report directly to the Health Care Administrator. Primary responsibilities of the clerk will include: referral arrangements; file and records management; medical and office supplies inventory management; reception and secretarial duties; and acting as interpretor for clients not fluent in English.

6.9 Maintenance/Housekeeping

The Health Authority will employ First Nation members to carry out routine maintenance and upkeep of facilities and non-medical supplies and equipment.

7.0 SWAMPY CREE TRIBAL DISTRICT HEALTH CENTRE

Chemawawin First Nation will participate with other member First Nations of the Swampy Cree Tribal Council in establishing a Tribal District Health Centre. The Tribal District Health Centre will be established as a non-profit corporation distinct from the Tribal Council. It will operate under a Board of Directors made up of appointed representatives from each of the participating First Nation Health Authority Boards of Directors. The Board of the Tribal District Health Centre will in no sense be superior to the Boards of First Nation Health Authorities.

The sole purpose of establishing the Tribal District Health Centre is to provide a mechanism allowing member Health Authorities to pool resources in order to provide for cost effective delivery of First Nation managed regional support health services. Regionally delivered services provided by staff and contract

personnel from the Tribal District Health Centre will include: itinerant physician, dental, environmental health and other specialist services; Medical Officer of Health services; research and program development services; professional support and supervision and inservice training for community based staff; recruitment, relief and staff rotation services; Health Board development programs; quality assurance and evaluation programs; medical boarding home and referral services; and co-ordination and promotion of access to the larger health care system and related programs.

A plan and budget for operation of the Swampy Cree Tribal District Health Centre has been prepared and will be submitted to Medical Services Branch shortly. The workplan for implementation would see negotiation of a transfer agreement for the Tribal Health Centre initiated in July of 1989 and an operational Health Centre established by March of 1990.

Until such time as the Tribal District Health Centre becomes operational, Chemawawin First Nation Health Authority will arrange for interim service delivery from a variety of sources which may include: existing Tribal Council programs (dental services, health advisor, NADAP coordinator); private clinics; hospitals; independent professionals; universities; and government agencies. The Health Care Administrator will be responsible for contracts management. Minimal interim contract service requirement will include the following:

- Physician Services - the Health Authority will contract with a clinic in The Pas for physician services including visiting services, supervision in medical delegated functions, participation in skills assessment and inservice training for community based staff, and program advisory services;

°Nursing Consultant - the Health Authority will make arrangement with Medical Services Branch for professional nursing supervision and consulting services while interchange arrangements are in effect;

°Medical Officer of Health - the Health Authority will contract with the Northern Medical Unit of the University of Manitoba for the services of a Medical Officer of Health with specialist training in public health (FRCP,MPH) to monitor and advise on public health and safety programs and participate in program development, staff inservice training and community education activities;

°Environment Health Officer - the Health Authority will contract with a qualified public health inspector to assist, advise and provide inservice training to CHR's in implementing the environmental/occupational health and safety surveillance program;

°Other Health Care Specialists - the Health Authority will contract for specialist services as required in areas such as mental health, nutrition, health education and traditional medicine;

°Drugs and Medical Supplies - the Health Authority will contract with St. Anthony's Hospital in The Pas for procurement of drugs and medical supplies;

°Program Evaluation - the Health Authority will contract with a qualified consultant to prepare a comprehensive program evaluation plan and data collection strategy;

°Facilities and Equipment Maintenance - the Health Authority will contract as required for facility and equipment maintenance and repair services which are beyond the capabilities of Health Authority staff;

°Transportation - the Health Authority will contract with a First Nation member for medical transportation services within the community and for ground transport of referrals to The Pas.

8.0 HEALTH PROGRAMS

8.1 Program Guidelines

As noted in the earlier discussion on strategy, we feel that the current MSB community health program is sound in concept. Accordingly the policies of the Board of Directors reference existing MSB manuals as procedural guidelines to be consulted by staff insofar as they are compatible with the management structure and policies of the Health Authority. MSB program manuals will be subject to evaluation as the transferred health program becomes established.

8.2 Family Health Care Programming

Family health care programming will encompass all components of the basic public health program currently delivered by MSB, including: maternal and child health; school health; chronic and elderly care; mental health; nutrition; and health education (communicable disease control and environmental/occupational health and safety are discussed in subsequent sections of this document). Objectives and activities in these areas are set out in MSB nursing service manuals. Where our program will differ from the current MSB program is in implementation.

In essence, family health care programming is a strategy for reorienting health care in Easterville towards a proactive service involving active client participation and co-ordinated team delivery.

There are three key components to the strategy.

1. Family Health Care Planning - Each staff nurse will have lead responsiblity for planning and co-ordinating team delivery of health services to specific client families/households in Easterville based on joint nurse-client assessment of family health care needs.
2. Periodic Health Assessment - A rigourous program of family oriented preventative care will be implemented based on the Periodic Health Assessment Schedule developed by Medical Service Branch.
3. Work Plannning - A weekly staff work planning process will be implemented to provide for co-ordinated team delivery of services.

Objectives, activities, responsibilities and targets for family health care are set out in Appendix B of this document.

As a planning program and a preventative care program, family health care programming should impact generally on health care delivery and contribute towards the goal on an improved level of health among community members. One measure of success would be reduction in standard morbidity and mortality figures. More subjective measures will also be used to provide a basis for quality assurance and program refinement, including: survey of staff and client opinions and perceptions; and periodic service reviews based on sample audits of family care plans, patient records and staff activity reports.

8.3 Communicable Disease Control

The communicable disease control program will be implemented in conjunction with the family health care program under the lead direction of responsible nurses. Immunization schedules are specified in the Periodic Health Assessment

Chart. Nurses will assess requirements for administration of additional immunizing agents with reference to Health and Welfare Canada's Guide to Immunization for Canadians and in consultation with the Medical Officer of Health. Each nurse will be responsible for:

°obtaining current certification for immunization;

°ensuring that his/her client families are familiar with the immunization schedule and promoting their participation;

°obtaining consents for immunization;

°monitoring of immunization levels and follow-ups of clients not up-to-date;

°identifying needs for a health promotion thrust on immunization and team work/requirements;

°planning and conducting regular immunization clinics in conjunction with other health staff;

°teaching control and prevention of communicable disease;

°administering immunizing agents;

°monitoring for symptoms of communicable disease, preliminary diagnosis and referral to a physician as required;

°T.B. screening;

°consultation with Medical Officer of Health as necessary;

°implementing physician prescribed patient care;

°contact tracing and follow-up with team support as appropriate;

°assisting the attending physician in completing Province of Manitoba notifiable disease reports and providing necessary information to the Manitoba Health Services Commission for participation in provincial MIMS program;

°participating in the development of annual reports including a narrative

review and assessment of program delivery and a summary of community immunization status and the incidence of communicable diseases.

8.4 Treatment Services

Primary treatment services will be provided by staff nurses and by visiting physicians and dental teams at the Chemawawin First Nation health facility. Requirements for secondary and tertiary care will be handled through referral and road or air transport of patients to The Pas, Winnipeg or elsewhere as appropriate. Referral requirements will be assessed by staff nurses in consultation with clients and a supervising physician or by visiting physicians and dentists. Referral arrangements will be co-ordinated by the staff clerk.

Inadequacies in medical transportation arrangements have been a serious and long standing concern for Easterville residents. At the present time there is no ambulance stationed in the community and the Manitoba Department of Health has not been authorizing aero-medevac transportation. In consequence, community residents are faced with the prospect of a minimum transport time to the nearest hospital in The Pas of 2½ hours if they use any available vehicle, or 5 hours if they wait for an ambulance from The Pas to pick them up. These lengthy transport times unnecessarily place seriously ill clients at risk. Chemawawin First Nation intends to see than an equiped ambulance vehicle and attendants are stationed in the community and that aero-medevac service arrangements are available when required.

Arrangements will be made with The Pas Clinic for provision of visiting and supervising physician services. Arrangements will be made with MSB for interim professional nursing supervision. Swampy Cree Tribal Council's dental care team will provide visiting dental care services. As at present, supplementary

interim dental services from MSB will be required to offset under-resourcing of the Swampy Cree Dental Program.

Nurses providing primary treatment services will function within the scope of duties for nurses working in MSB nursing station/treatment facilities and with reference to current MSB clinical guidelines and emergency protocols.*

Primary treatment services will be provided through:

- °establishing a regular schedule of open clinic hours with staff nurses in attendance;
- °ensuring that at least one nurse is stationed at the nursing station during regular office hours;
- °establishing a 24 hour on-call system to provide a prompt response to emergency situations;
- °providing weekly visiting physician clinics;
- °providing weekly visiting dental care clinics.

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*Swampy Cree Tribal Council is participating with the Manitoba Association of Registered Nurses, medical and pharmaceutical associations and federal and provincial government agencies in a process to define and recognize expanded nursing practice in Manitoba. This process will examine all functions and requirements for education, supervision, assessment and certification.

Nurse responsibilities will include:

°assessing health indicators of the community so as to determine program needs and organization of treatment clinic schedules according to needs;

°assessment of patients to determine requirements for in-patient or out-patient treatment or to determine whether medical attention is necessary;

°performing diagnostic x-ray examinations;

°performing simple diagnostic tests, to determine the presence of infection or disease in the body;

°providing counselling services as a result of diagnosis and treatment given;

°scheduling follow-up examination and treatment as determined by condition;

°determining the need for evacuation of patients requiring emergency medical attention not available at the nursing station and making arrangements for the evacuation as well as providing nurse escort if patient condition warrants;

°participating in provision of 24 hour intensive nursing care of patients admitted to the nursing station for serious illness, observation or further investigation pending medical evacuation to hospital or discharge home;

°selecting patients from among the population served who require non emergency medical or dental care and arranging for their attendance at physicians or dental clinics;

°assisting visiting medical personnel with assessment, dispensing, appointments, etc. in the clinic as necessary.

As noted earlier, heavy demand for treatment services has, in the past, been met at the expense of prevention and promotion aspects of health care. The Health Authority Board does not intend to allow this to continue. The Board's strategy for correcting the current program imbalance involves:

- °reducing the administrative workload of nursing staff through shifting these responsibilities to the Administrator and Administrative Officer;
- °providing staff with portable pagers, thus allowing more freedom to work outside the clinic, reducing the tendency towards overstaffing in the clinic, and facilitating on-call arrangements;
- °upgrading visiting physician services;
- °participation of visiting specialists in prevention and promotion program areas;
- °community education concerning roles and functions of health care providers in all program areas;
- °co-ordinating all staff activities through the work planning process;
- °reducing demand for treatment services through more effective disease prevention and health promotion program activities.

A quality assurance/evaluation program will be implemented, involving: sample audits of treatment charts; case reviews; surveys of client and staff opinions and perceptions; and monitoring of nursing activity reports and standard morbidity and mortality figures.

8.5 Environmental/Occupational Health and Safety

Health statistics for Chemawawin First Nation indicate high rates of incidence for accidents and injuries and various diseases associated with environment and living conditions. There is a clear need for a vigorous health and safety

program incorporating surveillance, preventative or corrective intervention and promotion. Community Health Representatives will take the lead in delivery of these services in cooperation with other health care staff and with the advice and assistance of an Environmental Health Officer and Medical Officer of Health.

The goal of the program is to meet and maintain generally accepted standards of environmental/occupational health and safety. It is recognized that preventative or corrective measures to meet these standards may require intervention by Chief and Council both within the community and with outside funding agencies. Community Health Representatives will be responsible for preparing quarterly reports on the program and recommendations for submission to the Health Care Administrator and presentation to the Board of Directors. Circumstances requiring more immediate action will be promptly communicated to the Health Care Administrator. The Board of Directors is responsible for advising Chief and Council.

CHR's will have the assistance and advice of a qualified public health inspector in implementing the inspection schedule set out in Appendix C. However, the major focus of the program, and the central priority for CHR's will be health and safety promotion through needs assessment, community education and organization of community projects.

8.6 Substance Abuse

The Native Alcohol and Drug Abuse Program currently administered by Chemawawin First Nation will be integrated with the health program. The

two substance abuse counsellors employed by the program will provide preventative counselling and public awareness services in co-ordination with other health program staff and will participate in the ongoing family health care program work planning process. Counsellors will submit quarterly activity reports to the Health Care Administrator.

Substance Abuse Counsellors will be responsible for on-going assessment of community, family and individual needs and for priorizing and planning program activities to address those needs. The following provides a partial inventory of such program activities.

1. Primary Prevention Activity - Taking action before serious problems start to develop. A primary prevention activity results in the community wide distribution of information. These activities are mainly intended to prevent initial abuse.
2. Secondary Prevention Activity - Dealing with an existing abuse problem at the earliest possible stage. A program or event that offers an activity as an alternative to abuse is a secondary prevention activity. These activities are mainly intended to prevent abuse before it becomes a serious problem.
3. Tertiary Prevention Activity - Helping people to prevent a problem from returning. An activity that involves Substance Abuse Counsellors working directly with individuals, families, or groups to stop or prevent further abuse.

Measures of success in program activities would include: reduction in alcohol and drug related incidents, accidents and deaths; increased participation in "dry" social activities; or positive responses to prevention activity participant surveys.

8.7 Community Health Promotion

Through the family health care work planning process the health care team will be involved in identifying "hot spots" for community health promotion. Hot spots would include problem areas such as accident prevention, nutrition education, community sanitation, AIDS education, mental health awareness or family planning. Team members will be responsible for targetting such areas for concerted team effort and developing strategies for effective intervention. At the outset, community awareness of Health Authority programs, structure and staff roles will be a central objective in this program area.

8.8 Emergency Planning

Representatives of Chemawawin First Nation have participated in an emergency preparedness workshop jointly sponsored by Swampy Cree Tribal Council and the provincial Emergency Measures Organization (EMO). A broad framework plan for community emergency response has been prepared using the EMO format. The framework plan sets-out authorities, implementation procedure, resource lists and emergency response roles at a general level. The plan will be submitted for review and publication by EMO and arrangements will be

made for testing the plan in the summer of 1989. Health Authority staff, under the direction of the Health Care Administrator, will be responsible for ensuring that an emergency response plan is prepared for the nursing station and is consistent with the community emergency response framework plan.

9.0 HEALTH RECORDS

At the outset, the Health Authority will adopt the Medical Services Branch treatment and community health charting system. This system will be subject to evaluation as the transferred health program becomes established. Records will be kept in a secure area and will be the property of the Health Authority. Records access will be restricted to the health care team who will be required to sign an oath of confidentiality clause in employment contracts; and to clients who may wish to review their personal charts.

12.0 TRAINING PLAN

10.0 LIABILITY

Chemawawin First Nation Health Authority will purchase comprehensive employers liability insurance coverage from the firm of Marsh and McLennan Ltd. This will include primary coverage for the Board of Directors, employees,* facilities and equipment. Vehicle insurance coverage will be purchased from the Manitoba Public Insurance Corporation. Professional staff and contractors will be required to maintain coverage through their professional associations.

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*Until such time as legal and liability issues associated with expanded nursing practice are resolved, nurses will receive primary coverage through the Interchange Canada Program.

11.0 EVALUATION

A multifaceted evaluation program will be implemented:

°staff and advisory personnel will be involved in ongoing formative evaluation and program development through the work planning process;

°the Health Authority will participate with Medical Services Branch and the Canadian Council on Health Facilities Accreditation in their proposed pilot project to develop quality assurance standards and an accreditation program for community health services;

°the Health Authority will contract for development of a comprehensive five year data collection and program evaluation/quality assurance program in the initial year of transfer.

12.0 TRAINING PLAN

The Health Care Administrator in consultation with staff and consulting personnel, will be responsible for assessing staff training requirements on an on-going basis and for developing a plan for skills up-grading and professional development which is in keeping with community service needs. The Adminstrator will also assist the Board of Directors in evaluating their own training requirements.

Until such time as Health Authority staffing is initiated, training plan components can be identified only at a general level as follows:

°Community Orientation and Cultural Awareness - coordinated by CHR's, provided for all new staff;

°Inservice Training - provided by visiting specialists to all staff according to assessed needs and training plan;

°Certification in Health Care Administration - offered by correspondence from the University of Saskatchewan, required training for Special Administrative Officer;

°National Clinical Training Program and Community Health Inservice Program - offered by MSB, required by all staff nurses not previously trained in these areas;

°NNADAP Training - sponsored by NADAP, ongoing training required by substance abuse counsellors;

°CHR Training - sponsored by MSB, ongoing training required by CHR's;

°Health Board Development - as appropriate to meet needs of current and new Board members;

°Expanded Nursing Practice Assessment/Certification - as determined through current joint First Nation, government and professional association review of expanded practice in Manitoba.

13.0 FACILITIES AND EQUIPMENT

The provincial government has not released plans or disclosed what funding commitments may have been made for construction of a new health facility in Easterville. One might anticipate a facility similar to the provincial nursing station in Grand Rapids or Moose Lake. Preliminary inspections of such facilities, and discussions with provincial health care employees sugges significant deficiencies in design and equipment. Accordingly, we feel it is imperative that Chemawawin First Nation administer both the planning and

construction of the new health facility in Easterville, regardless of funding source.

14.0 IMPLEMENTATION

With submission of this Community Health Plan the Board of Chemawawin First Nation Health Authority, as authorized by Chief and Council, have initiated the implementation process. We wish this process to progress without delay. Our tentative time frame for negotiations, as set out in Appendix D, would see signing of a transfer agreement in March of 1990.

15.0 FUNDING

The Board has directed that a Health Authority budget be prepared based on estimated costs of operation in the first year of transfer and projection of costs in years 2 through 5. The budget is attached as Appendix E. Costing techniques applied in developing the budget are referenced in attached notes to the budget.

APPENDIX A

COMMUNITY HEALTH

ASSESSMENT DATA

TABLE 1

HOSPITAL CASES* JUNE 1984 - JUNE 1987 SELECTED CAUSES

Diagnostic Category	Chemawawin First Nation Cases/1000	% of Total No. of Cases	All Manitobans Cases/1000	% of Total No. of Cases
1. Infectious & Parasitic Diseases	15.7	3.3	2.0	1.4
2. Neoplasms	3.9	.8	9.3	6.4
3. Endocrine, Nutritional & Metabolic	9.1	1.9	2.5	1.7
5. Mental Disorders	6.5	1.4	5.9	4.0
6. Nervous System Diseases	13.7	2.9	6.2	4.3
7. Circulatory System Diseases	9.7	2.0	16.2	11.2
8. Respiratory System Diseases	103.9	21.7	16.3	11.2
9. Digestive System Diseases	54.7	11.4	16.1	11.1
10. Genitourinary System Diseases	33.9	7.1	9.9	6.8
11. Obstetrical Conditions	86.6	18.0	22.4	15.4
12. Skin & Subcutaneous Diseases	14.9	3.1	2.1	1.4
16. Signs & Symptoms 111-defined	25.9	5.4	8.2	5.7
17. Injury & Poisioning	70.9	14.8	12.5	8.6
18. Special Conditions	14.9	3.1	8.4	4.4
Average Annual Rate of Admission all Diagnostic Categories	479.7		145.2	

*Based on Manitoba Health Services Commission Hospital Utilization Reports.

TABLE 2

CHEMAWAWIN FIRST NATION COMMUNITY HEALTH NEEDS ASSESSMENT QUESTIONAIRE RESPONSES

Community Members – Perceived Problems

1) Poor Housing
2) Unsanitary Conditions
3) Accidents and Injuries
4) Alcohol and Drug Abuse
5) Physical Illness
6) Mental Health
7) Family Planning
8) Poor Nutrition
9) Violence
10) Emotional Illness

Key Informants – Perceived Problems

1) Poor Housing
2) Alcohol and Drug Abuse
3) Unsanitary Conditions
4) Accidents and Injuries
5) Poor Nutrition
6) Personal Hygiene
7) Diabetes
8) Family Planning
9) Physical Illness
10) Violence

Key Informants – Program Enrichment Needs

1) Alcohol and Drug Abuse
2) Water and Sanitation
3) Nutrition Education
4) Family Planning
5) Health Education
6) Housing
7) Elderly Care
8) Mental Health
9) Childcare
10) Recreation

TABLE 3

Easterville

Nursing Activities in Descending Order
of Percentage of 1:1 Activities Recorded (Nursing Activity 1), 1983-1986 Calendar Years

NC = Nursing Care T = Teaching C = Counselling

1983		1984		1985		1986	
Nursing Activity	% of Total 1:1 Activities	Nursing Activity	% of Total 1:1 Activities	Nursing Activity	% of Total 1:1 Activities	Nursing Activity	% of Total 1:1 Activities
NC-Dermatologic	19.4	NC-Dermatologic	20.8	NC-Dermatologic	16.0	NC-Ear,Nose,Throat	17.3
NC-Ear,Nose,Throat	11.0	NC-Ear,Nose,Throat	12.6	NC-Trauma,Initial	12.3	NC-Trauma, Initial	14.9
NC-Gastrointestinal	9.9	NC-Gastrointestinal	10.9	NC-Ear,Nose,Throat	10.6	NC-Gastrointestinal	12.1
NC-Trauma	8.2	NC-Trauma	9.1	NC-Lower Respiratory	9.7	NC-Trauma, Follow-up	9.7
NC-Genitourinary	6.8	NC-Upper Respiratory	7.3	NC-Gastrointestinal	9.0	NC-Endocrine/Metabolic	6.7
NC-Upper Respiratory	5.8	NC-Genitourinary	7.2	NC-Genitourinary	6.7	NC-Lower Respiratory	6.7
T-Nutrition	5.7	NC-Endocrine/Metabolic	6.5	NC-Trauma, Follow-up	6.4	NC-Dermatologic	6.6
NC-Musculoskeletal	5.3	NC-Lower Respiratory	3.9	NC-Upper Respiratory	5.9	NC-Genitourinary	4.4
T-Cardiovascular	4.7	NC-Dental/Oral	3.4	NC-Endocrine/Metabolic	4.8	NC-Musculoskeletal	2.6
NC-Endocrine/Metabolic	4.6	T-Cardiovascular	2.6	NC-Musculoskeletal	3.2	NC-Upper Respiratory	2.3
Total 1:1 Activities in Column 1 = 433		Total 1:1 Activities in Column 1 = 2,058		Total 1:1 Activities in Column 1 = 10,367		Total 1:1 Activities in Column 1 = 2,534	

SOURCE: Manitoba Health Community Health Services

APPENDIX B

FAMILY HEALTH CARE PROGRAMMING

FAMILY HEALTH CARE PROGRAMMING (continued)

OBJECTIVES/ACTIVITIES	RESPONSIBILITY	SUCCESS CRITERIA/TARGETS/OUTPUTS
PERIODIC HEALTH ASSESSMENT		
Objective:		
To implement a vigorous program of family oriented health monitoring and preventative care based on the Periodic Health Assessment Schedule developed by Medical Services Branch and joint client-nurse assessment of services needs.	Each staff nurse will have lead responsibility for ensuring and coordinating service delivery to their respective client families (as with Program Planning).	Service delivery as per schedule and assessed needs.
Activities:		
°Orientation - home visits to introduce program in conjunction with program planning orientation and needs assessment.	Nurses, CHR's, clients	Initial orientation within two months of start-up.
°Implementation - through work planning process.	Health care team	Service delivery as per schedule and assessed needs.

FAMILY HEALTH CARE PROGRAMMING (continued)

OBJECTIVES/ACTIVITIES	RESPONSIBILITY	SUCCESS CRITERIA/TARGETS/OUTPUTS
Work Planning		
Objective:		
To establish a weekly health care team work planning process to provide for coordinated delivery of community health services to meet community health needs.	Health care team. Health Care Administrator directs planning process.	Weekly staff workplanning meetings initiated at start-up.
Activities (Weekly)		
°Review Service Requirements - team members to identify service needs and priorities within their respective areas of lead responsibility.	Lead Responsibilities Nurses - client family health care, treatment services. CHR's - health and safety surveillance and promotion. NADAP - substance abuse prevention CLERK - office management, referrals MAINTENANCE/HOUSEKEEPING facilities and equipment upkeep. HEALTH CARE ADMINISTRATOR program management, direct workplanning process.	Coordinated weekly work plans and activity schedules.
°Identify areas for coordinated action - child health clinics, immunization clinics, physicians clinics, school health, prenatal classes, etc.		
°Develop/negotiate coordinated workplan.		
°Prepare individual activity schedules.		
°Review workplans against performance at week end.		

APPENDIX C

Environmental/Occupational Health and Safety

Inspection Schedule

ENVIRONMENTAL / OCCUPATIONAL HEALTH AND SAFETY

INSPECTION SCHEDULE

ACTIVITIES	REPORTING / OUTPUTS
• Review and update community profile annually.	• Review completed.
• Monitor the water sampling program for chemical parameters. a) Community water supplies. b) Private water supplies.	• Annual chemical sample submitted. Recording of test results and any follow-up action. Recording of test results and any follow-up action.
• Monitor the water sampling program for biological parameters. a) Community water supplies. b) Private water supplies.	• Monthly bacteriological smaples submitted. Recording of test results and any follow-up action. Recording of test results and any follow-up action.
• Inspection of community water treatment plant (4 times per year).	• 4 inspections completed. Recording of results and follow-up action.
• Inspection of private water supplies upon request	• Recording of request and follow-up action.
• Respond to complaints involving public or private water supplies.	• Recording of complaint and follow-up action.

ACTIVITIES

- Inspection of community waste disposal site (once per year)

- Inspection of community sewage treatment facility (twice per year).

- Monitor the sewage effluent sampling program (monthly).

- Examination of new private sewage disposal installations to determine compliance with provincial regulations.

- Respond to complaints involving public or private sewage disposal systems.

- Inspection of school (twice per year).

- Inspection of food stores / restaurant (twice per year)

- Annual inspection of Band Office.

REPORTING / OUTPUTS

- 1 inspection completed.
  Recording of results and follow-up actions.

- 2 inspections performed.
  Recording of results and follow-up action.

- monthly samples submitted
  Recording of the number of inspections performed and any follow-up action.

- Recording of the number of inspections performed and any follow-up action.

- Recording of complaints and follow-up action.

- 2 inspections completed.
  Recording of results and follow-up action.

- 2 inspections completed each facility
  Recording of results and follow-up action.

- Inspection completed.
  Recording of results and follow-up action.

ACTIVITIES

- Annual inspection of health centre.

- Respond to complaints involving facilities or premises.

- Monitoring of known and suspected environmental contaminants.

- Respond to complaints involving environmental concerns and workplace safety.

- Support communicable disease outbreak

- Review of construction plans.

  a) For all new public facilities.

  b) For new commercial facilities upon request.

  c) For new private facilities upon request.

- Quarterly reports on activities to Health Care Administrator

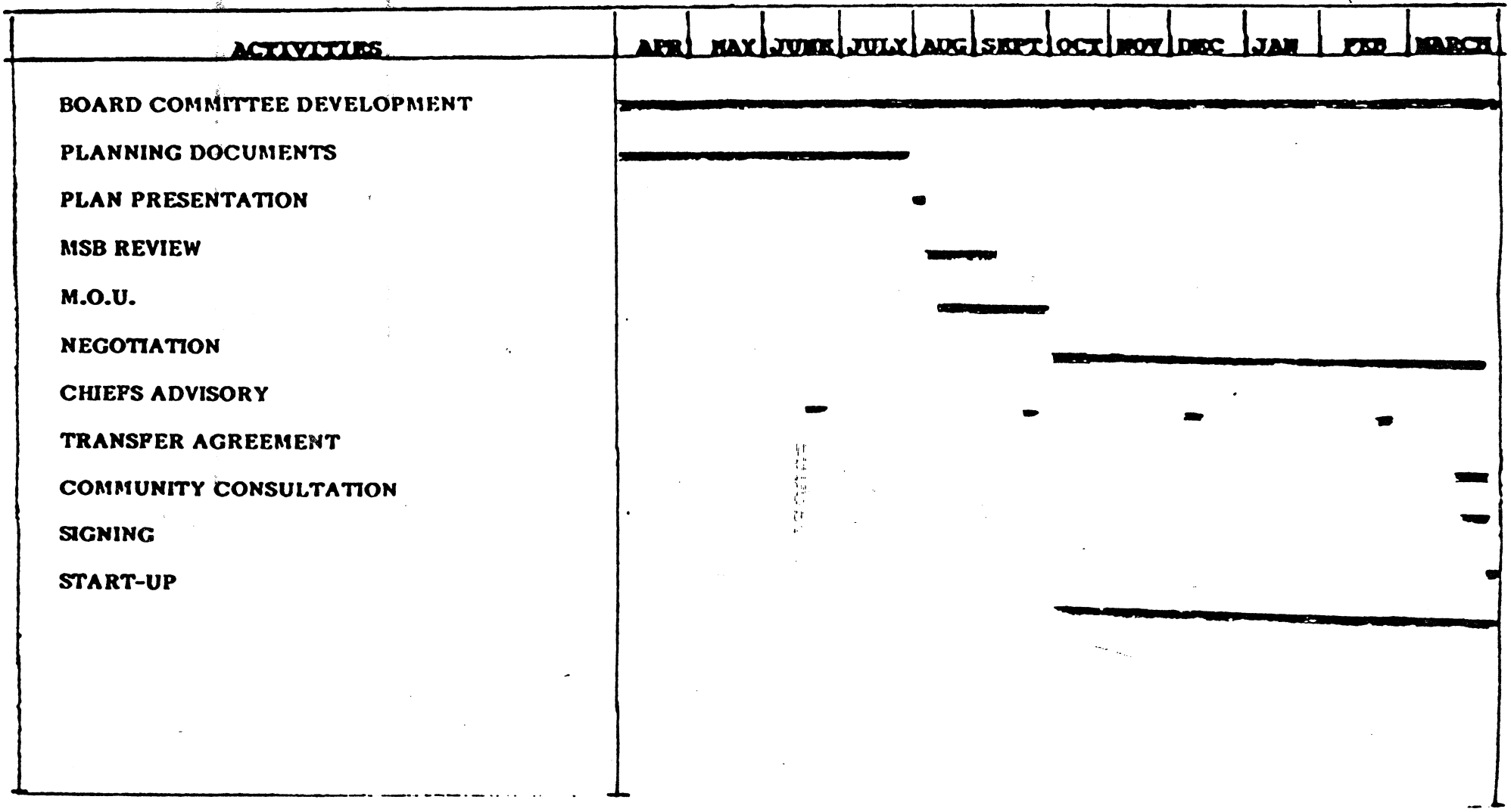
	RECORDING / OUTPUTS
	° Inspection complete. Recording of results and follow-up action.
	° Recording of complaints and follow-up action.
	° Recording of any monitoring and follow-up action.
	° Recording of complaints and follow-up action.
	° Recording of involvement.
	° Recording of involvement. ° Recording of involvement.
	° Reports submitted.

APPENDIX D

IMPLEMENTATION WORKPLAN

CHEMAWAWIN FIRST NATION
IMPLEMENTATION WORKPLAN
89/90

TABLE 1



APPENDIX E

BUDGET

BUDGET YEAR ONE

CATEGORY A: COMMUNITY BASED

1. Salaries and Benefits

a)	Health Care Administrator	$ 50,630.00
b)	Special Administrative Officer	$ 44,880.00
c)	Nurses (2)	$114,300.00
d)	Community Health Representative (2)	$ 64,460.00
e)	Substance Abuse Counsellors (2)	$ 64,460.00
f)	Clerk	$ 32,906.00
g)	Maintenance/Housekeeping	$ 27,630.00

Total Salaries and Benefits	$ 399,266.00
2. Overtime/Relief	$ 59,890.00
3. Board Honoraria/Expenses	$ 22,468.00
4. Travel	$ 35,000.00
5, Training	$ 23,000.00
6. Operating	$ 150,000.00
7. Insurance	$ 7,000.00
8. Audit	$ 3,500.00
Total Category A	$ 700,107.00

CATEGORY B:: CONTRACT SERVICES

1.	Physician	$ 54,000.00
2.	Medical Officer of Health	$ 12,600.00

3.	Nursing Supervision	$ 12,000.00
4.	Environmental Health Officer	$ 4,000.00
5.	Evaluation/Quality Assurance Consultant	$ 15,000.00
6.	Other Specialists	$ 9,600.00
7.	Drugs and Medical Supplies	$ 65,000.00
8.	Transportation	$ 200,000.00
9.	Maintenance/Repair	$ 15,000.00
10.	Audit	$ 1,936.00
11.	Overhead	$ 18,492.00
	Total Category B	$ 407,628.00
GRAND TOTAL CATEGORIES A AND B		**$1,107,735.00**

BUDGET PROJECTION

YEAR TWO	$1,163,121.80
YEAR THREE	$1,269,277.80
YEAR FOUR	$1,332,741.70
YEAR FIVE	$1,399,378.80 + 69,968.94 (evaluation - 5% total) $1,469,347.80

BUDGET NOTES

PRINCIPLES

Several principles underlie the budget calculations.

°The Health Authority must be in a financial position which allows it to compete for staff and services with other employers.

°Price and volume increments must be built into the budget so as to avoid diminishing service capabilities.

°The Health Authority must be capable of providing service levels comparable to those enjoyed by other Canadians.

°The Health Authority budget must incorporate sufficient contingency resources to allow flexibility in responding to unforseen circumstances.

BUDGET - YEAR ONE

Category A: Community Based

1. Salaries and Budgets

a) Health Care Administrator: A salary of $40,000.00 is included based on discussion of expected rates for a fully qualified and experienced Administrator, with the Director of the Health Care Administration program at the University of Saskatchewan. Benefits are at 15%. Isolated Post Allowance (I.P.A.) at current Treasury Board approved rate for a married employee is at $4,630.00.

b) Special Administrative Officer: A salary of $35,000.00 based on MSB's Health Management Co-ordinator guideline, plus 15% benefits plus I.P.A.

c) Nurses: Salaries based on current PIPS Collective Agreement rates for NU-CHN4 ($42,270.00) and NU-CHN3 ($39,069.00) plus interim nursing group settlement ($5000.00 x 2) plus 15% benefits plus I.P.A.

d) Community Health Representative: At present, CHR's are employed at PHS category

salary rates. The PHS category is being reviewed by the federal government in response to a Human Rights Commission ruling and the category is to be upgraded. In view of this we have employed a proxy of $24,000.00 x 2 plus 15% benefits plus I.P.A.

e) Substance Abuse Counsellor: Same as for CHR's.

f) Clerk: The clerk position will encompass referral and office management responsibilities. We have used a CR-4 salary rate ($24,588.00) plus 15% benefits plus I.P.A.

g) Maintenance/Housekeeping: Based on full time equivalent at a salary of $20,000.00 plus 15% benefits, plus IPA.

2. Overtime/Relief

Calculated at 15% of total salaries and benefits.

3. Board Honoraria/Expenses

MSB's health management funding guideline for a community of 1000 members adjusted for and remoteness (19,149 / 3 x remoteness index .52 +19,149)

4. Staff Travel

Several bases: monthly travel to The Pas for four staff ($220.00 x 12 x 4); travel to Winnipeg (9 trips at $500.00) and MSB guideline of $10,000.00 for health management travel.

5. Training

Based on $2,000.00 x 9 employees plus $5000.00 for Health Board development.

6. Operating/Maintenance

Based on historic operating and maintenance of $154,989.00 in 1987/88 for the nursing station in Pukatawagan.

7. Insurance

Several bases: Marsh and McLennon estimate of $3,000.00 for employers and facility; Sandy Bay premiums of $5,414.00; MPIC rates of $900.00 bussiness insurance on van, $352.00 on ski-doos and $274.00 on ATC.

8. Audit

MSB guideline of .005 of total budget.

Category B: Contract Services

1. Physician

Booz-Allen recommended service level of about 120 days per year x fee for service differential $450.00 per day.

2. Medical Officer of Health

Three days bi-monthly at $500.00 per day plus $600.00 travel for each of six trips from Winnipeg to Easterville..

3. Nursing Supervision

One quarter of NU-CHN4 salary benefits and I.P.A. (The Pas) payable to MSB during Interchange agreement.

4. Environmental Health Officer

Ten days at $400.00 per day.

5. Evaluation/Quality Assurance Consultant

Twenty-five days at $600.00 per day.

6. Other Specialists

Twenty-four days at $400.00 per day.

7. Drugs and Medical Supplies

Historic expenditures on Pukatawagan nursing station drugs and medical/surgical supplies of about $50,000.00 plus 30% service charge to supplier.

8. Transportation

Several bases: MSB medical transportation expenditures of$150,000.00 for Chemawawin members in 1985/86 were 50% higher than in 1983/84; locally administered patient transportation expenditures in 1985/86 of $117,000.00 in Shoal River (population 450) and $46,200.00 in Indian Birch (population 120).

9. Maintenance/Repairs

Based on facility and equipment repair expenditures at Pukatawagan averaging out in the neighborhood of $14,000.00.

10. Audit

Based on MSB guideline of .005 of budget total for category B.

11. Overhead

Total contract services x MSB basic overhead percentage (4.05%) adjusted for remoteness (basic overhead / 3 x .52).

BUDGET PROJECTION

The year one budget is projected at an annual growth of 5% reflecting a 5% Consumer Price Index. Population growth has been factored in by employing the projected 1995 population of 1000 in the year one budget. This projection includes both natural increase and growth resulting from Bill C-31. In year three a fourth nursing position (at $48,000.00 including benefits and I.P.A.) has been added to reflect plans for development of an integrated extended care program. The budget for the fifth year includes funds for program evaluation as required by MSB. This was calculated by adding 5% to that year's budget as per MSB guideline on evaluation costs.

Approved By:

Number: 1 - 40

Date:

Category: Administrative Overview

ANNUAL REPORT

The First Nation Health Authority will issue an Annual Report and Audited Financial Statement within ninety (90) days of the end of the fiscal year. The report will constitute the principal means by which the Health Authority will be accountable to First Nation Members and funding agencies. In addition to financial information the report will include: narrative and statistical summaries of activities and health status indicators in each program area: a general assessment program achievement in relation to objectives: a review of program development plans: and a five year budget projection.

Approved By:

Number: II - 10

Date:

Category: Treatment Services

PRIMARY CARE TREATMENT SERVICES

Primary care treatment services will be provided by staff nurses, visiting physicians and visiting dental care teams at the Nursing Station facility through:

- ° establishing a regular schedule of open clinic hours with staff nurses in attendance:
- ° ensuring that at least one nurse is stationed at the nursing station during regular office hours:
- ° establishing a 24 hour on-call system to provide a prompt response to emergency situations:
- ° providing weekly visiting physicia clinics:
- ° providing weekly visiting dental care clinics.

Approved By:

Number:

Date:

Category: Treatment Services

NURSE PROVIDED PRIMARY CARE TREATMENT - SCOPE OF DUTIES

Nurses providing treatment services will operate within the recognized scope of duties for nurses providing primary care treatment services and within their own professional competencies. Nurse competencies will be assessed according to the procedures established by the Manitoba Association of Registered Nurses. The Health Care Administrator will be notified of any requirements for skills upgrading of nursing staff. The Health Authority may arrange for skills upgrading.

Primary care treatment services will be provided in conformity with recognized nursing practice and standard nursing procedural manuals including:

Clinical Guidelines for Medical Services Personnel. Medical Services Branch, Health and Welfare Canada.

Primary Care Nursing. Hazlett

A Textbook for Midwives.

Dmn

MEDICAL SERVICES BRANCH
SCOPE OF DUTIES
COMMUNITY HEALTH NURSES

NURSING STATION FACILITY/TREATMENT FACILITY

Introduction

The Scope of Duties establishes the parameters for Community Health Nurses, working in Medical Services nursing station/treatment facilities, to provide treatment services. Limitations may be established by specific Regional Policies. Nurses are personally and professionally responsible for familiarizing themselves with the scope of duties established by the Region in which they are working, and to practice and undertak those procedures for which they have training, experience and competence.

It is the responsibility of the manager to review the scope of duties before inclusion in present or future nurse's job description and to ensure the nurse is qualified and/or a training plan is provided.

Any nurse who does not feel qualified to carry out the functions will not be required to do so, but must take steps to inform management.

A. In the performance of Community Health Nursing responsibilities in a nursing station/treatment facility working environment, the Community Health Nurse is required to be knowledgeable and skillful in recognition and management of the following:

1. Common medical disorders affecting adults which are cared for in an outpost situation; and temporary management of patients with more serious illness requiring referral to hospital.

2. Common pediatric problems which are cared for in an outpost setting and their management based on a basic understanding of normal growth and development and well child care, and a temporary management of patients with more serious pediatric illness requiring referral to hospital.

.../2

3. Common obstetrical conditions which are cared for in an outpost situation based on basic understanding of physical and emotional care required by the normal obstetrical client and her infant through the maternity cycle and temporary management of patients with more serious obstetrical problems requiring referral to hospital.

4. Acute emergency problems requiring medical and surgical intervention such as lacerations, gun-shot wounds, fractures, abrasions, head injuries, burns and initial management of patients with more serious emergency problems which must be cared for at a nursing station until referral and transport can be arranged.

5. Clients with orthopedic problems; emergency treatment; assessment for referral.

6. Clients with psychiatric problems; temporary management; referral for treatment and follow-up management.

7. Preparing clients for and managing a client during any evacuation, requiring medical or nursing escort.

B. The acute, chronic and emergency conditions referred to in 1 to 7 will include but not be restricted to the following:

1. Infections and inflammations
2. Acute alcoholic poisonings, overdoses
3. Thermal injuries, hot and cold
4. Seizure disorder, including febrile convulsions
5. Acute abdomen
6. Lacerations and wounds
7. Respiratory conditions, including asthma
8. Musculoskeletal conditions including fracture, joint injuries and connective tissue injuries
9. Hemorrhage or Epistaxis
10. Pneumothorax

.../3

11. Obstetrical emergencies including premature labour and delivery and threatened abortion as well as full term deliveries
12. Psychiatric disorders
13. Opthamalogical conditions including cataracts, acute glaucoma and eye emergencies
14. Foreign body in eye, ear or nose
15. Dehydration
16. Gastro intestinal diseases including gastroenteritis
17. Allergies and allergic reactions
18. Gynecological conditions
19. Acute cardiovascular conditions, including cerebrovascular accidents
20. Dental injuries
21. Management of chronic conditions such as hypertension; diabetes and other endocrine problems
22. Dietary problems (obesity, malnourishment)
23. Sexually transmitted diseases
24. Neurological conditions
25. Otopharyngeal conditions

C. The following functions are performed by the Community Health Nurses in the context of their duties in a nursing station/treatment facility in dealing with common health problems or in an emergency situation:

1. History taking, determination of mental status, and physical assessment to include specific examination (adult & child) for differential diagnosis. Will consider body systems:

   a) skin
   b) head and neck
   c) respiratory system
   d) cardiovascular system
   e) peripheral vascular system
      - veins
      - arteries
      lymph system
   f) reproductive system
   g) upper and lower gastrointestinal system
   h) musculoskeletal system
   i) nervous system
   j) genitourinary system

.../4

2. Managing common health problems by initiating:

a) Drug therapy as directed by medical standing orders and guidelines and/or consultation
b) Minor surgical procedures
c) Medical intervention
d) Consultation and referral
e) Counselling techniques.

3. Undertake specific procedures including:

a) immunization
b) IV therapy, venipuncture, injections
c) control of hemorrhage
d) C.P.R. including resuscitation of the newborn
e) gastric lavage
f) suturing
g) eye examination, fluor staining vision screening
h) x-ray (basic chest and limbs) and initial interpretation
i) splinting and immobilization
j) cast application (i.e. slab cast)
k) incision and drainage of abscess
l) audiometric screening
m) assessment and management of labor and delivery
n) episiotomy
o) use of emergency drugs
p) collection of specimens: sputum, blood, urine, pap smear, etc.
q) sexual abuse protocol
r) management of sexually transmitted diseases
s) temporary management of dental emergencies, such as broken teeth, fractured jaw
t) inserting/removal by string only, of IUD's

.../5

4. Use of specific equipment:

a) oxygen
b) EKG machine
c) incubators
d) entonox
e) mist tents
f) otoscopes
g) Nasopharyngeal and/or Brookes airway
h) laryngoscopes
i) ophthalmoscopes
j) tonometer
k) transportable/portable x-ray machine
l) resuscitators
m) suction equipement
n) audiometer screening
o) microscope

5. Laboratory tests which may include obtaining a specimen and sending it out to the laboratory or obtaining the specimen and doing the test:

a) Hgb. - W.B.C.
b) sed rate
c) prepares cultures
d) pregnancy test
e) urinalysis and microscopy
f) wet mount smears for trichomonas
g) pap smear
h) blood smear
i) microscopy of vaginal and urethral smears

Approved By:

Number: II - 30

Date:

Category: Treatment Services

PROFESSIONAL SUPERVISION AND SUPPORT - PRIMARY CARE NURSES

Professional supervision and support for nurses providing primary care treatment services will be provided by physicians at The Pas Clinic and by a consulting senior nurse under contract to the Health Authority. Supervision and support will be provided through ensuring telephone consultation services are accessible on a 24 hour basis and by providing for community visits by consulting physicians and senior nurses as required. The Health Care Administrator is responsible for contract arrangements for professional supervision and support.

Approved By: Number: II - 40

Date: Category: Treatment Services

UTILIZATION OF IN-PATIENT FACILITIES AT NURSING STATIONS

1. The admission of a patient to the Nursing Station should be determined by:

   a. The medical condition of the patient.

   b. The professional capabilities of the nurses at the station.

   c. The staffing situation - nurses, ancillary staff.

   d. Weather conditions, communication and transportation factors.

2. Cases to be considered for Nursing Station admission:

   a. Any medical emergency requiring stabilization prior to further assessment.

   b. Those patients whose condition warrants evacuation and are awaiting transportation due to darkness, inclement weather, or transportation delay.

   c. Those requiring observation, especially pediatric cases. (a family member should be requested to stay with the patient).

   d. Those cases requiring short term medical care (24-72 hours) that is unavailable in the home (e.g., pyrexia, bronchitis, gastroenteritis).

   e. Obstetric emergencies or cases in well-established labour.

3. Arrangements should be made for all obstetrical patients to be delivered in hospital.

4. When obstetrical patients are delivered in the nursing station, they should be kept a minimum of 48 hours and then discharged home with home visits made daily for ~~3-4~~ 3, 6 days. Evacuation should occur only if complications arise that can not be managed at the nursing station.

5. Medical consultation should be considered where appropriated.

Approved By:

Number: T-50

Date:

Category: Treatment Services

DELIVERY IN NURSING STATION

All deliveries should be planned for hospital. In the event that a patient goes into delivery unexpectedly and it is determined on examination that delivery is imminent, the patient should be admitted to the nursing station for delivery.

The delivery should be carried out according to A Textbook for Midwives by Margaret Miles and Primary Care Nursing by Hazlett. Arrangements should be made for consultation with a physician. In addition the following should be noted:

1. Cord blood should be taken and sent to the lab for mercury, hemoglobin and/or Coombs test if indicated.

2. Newborn requires a single 1 mg dose of Vitamin K (Phytonadione Injectable I.M. Fat Soluble) to prevent hemorragic disease of the newborn.

3. The mother and infant should remain in the Nursing Station for a minimum of 48 hours after delivery and after discharge should be visited daily at home for 10 days.

4. Mother and infant should be evacuated to hospital only if complications occur.

5. On the third day after birch B.C.G. vaccination should be given.

6. P.K.U. is done by heal prick 48 hours after the infant has been feeding on milk. For premature of ill infants a repeat sample is recommended.

7. Complete the Provincial Birth and Still Birth Registration Form.

Approved By: Number: -7-60

Date: Category: Treatment Services

SECONDARY AND TERTIARY CARE TREATMENT SERVICES

Requirements for secondary and tertiary care treatment services will be met through referral and air transport of clients to facilities in The Pas, Winnipeg or elsewhere as appropriate (see referral policy number VIII-10). Requirements for secndary and tertiary care will be assessed by staff nurses and consulting physicians.

Approved By:

Number: III · 10

Date:

Category: Family Health Care Program

PROGRAM DELIVERY RESPONSIBILITIES

Beyond meeting requirements for provision of treatment services, family health care will be the priority program for nursing staff. Each nurse will be assigned lead responsibility for program delivery to a share of the families/households in the community. Workload allocation will be determined by the Health Care Administrator in consultation with health care staff.

While staff nurses will have a lead role in program delivery all members of the health care team (nurses, community health representatives, substance abuse counsellors and cntract/support health professionals) will participate in the family health care program. Team roles will be determined on an on-going basis through the staff work planning process.

Approved By:

Number: III - 20

Date:

Category: Family Health Care Program

PERIODIC HEALTH ASSESSMENT

The Family Health Care Program will be based on the periodic health assessment schedule developed by the Medical Services Branch of Health and Welfare Canada (chart attached). Each nurse is responsible for ensuring that his/her client families are receiving scheduled services.

The health assessment schedule represents a minimum standard of care. In addition, each nurse is responsible for:

- developing, maintaining current and implementing a nursing plan of care for each client based on the assessed needs of that client;
- identifying requirements for participation of community health representatives substance abuse counsellors, physicians, dental care team, environmental health officers and others;
- identifying areas for coordinated action (e.g. child health clinics, immunization clinics, school health, physician clinics, prenatal classes etc.);
- coordination of program delivery with other members of the health care team.

PERIODIC HEALTH ASSESSMENT

PRENATAL

HISTORY TAKING & PHYSICAL EXAMINATIONS	1-13 weeks or 1st visit	14-27 weeks	28-30 weeks	31-33 weeks	34-36 weeks	37-40 weeks	POST PARTUM
Complete Assessment							
Obstetric Examination	← MONTHLY →		← 2 WEEKLY →			WEEKLY	
Pelvic Examination							
Measurement of Weight	← MONTHLY →		← 2 WEEKLY →			WEEKLY	
Measurement of Blood Pressure	← MONTHLY →		← 2 WEEKLY →			WEEKLY	
Prenatal Scoring					36 WEEKS		

COUNSELLING	1-13 weeks or 1st visit	14-27 weeks	28-30 weeks	31-33 weeks	34-36 weeks	37-40 weeks	POST PARTUM
Needs Assessment							
Nutrition							
Breastfeeding							
Abstinence from Smoking							
Alcohol consumption Chemical Abuse							
Family Planning							
Post Partum Depression							
Parenting							

LABORATORY INVESTIGATION	1-13 weeks or 1st visit	14-27 weeks	28-30 weeks	31-33 weeks	34-36 weeks	37-40 weeks	POST PARTUM
Hemagglutination inhibition test for rubella							
Serologic testing for Toxoplasma gondii		If Positive			If previous negative		
Testing for mercury							
Serologic testing for syphilis							
Determination of Blood Group and Screening for Antibodies							
Screening for Anti-D Antibodies in RH negative Mothers		← BI-WEEKLY FROM 20 WEEKS ONWARD →					
Determination of Hemoglobin Concentration	← MONTHLY →		← EVERY TWO WEEKS →				
Culture of Cervical and Urethral Secretion for Gonorrhea							
Papanicolaou Smear							
Testing for Proteinuria and Glycosuria	← AT EVERY VISIT →						
Blood Glucose Testing (Fasting & Postcibal)							
Glucose Tolerance Test							
Urinalysis and Urine Culture							
Ultra Sound		15-25 weeks					

☐ Essential for all persons ☐ High Risk

☐ All Persons with indicated need

NOTE: THIS CHART WAS DEVELOPED SPECIFICALLY FOR THE USE OF MEDICAL SERVICES, MANITOBA REGION AS A RESULT OF A PILOT PROJECT COORDINATED BY THE SENIOR NURSES OF MANITOBA REGION.

INFANTS (BIRTH - 17 MONTHS)

HISTORY TAKING AND PHYSICAL EXAMINATIONS	BIRTH	1st week or 1st visit	2 - 4 weeks	2 months	4 months	6 months	9 months	12-15 months
Examination for Post-natal asphyxia, blood group incompatibility								
Instillation of 1% silver nitrate solution into each eye								
Administration of 1 mg of Vitamin K_1								
Complete physical assessment								
Clinical examination of cardiac murmurs								
Measurement of length, weight & head circumference								
Examination for dislocation of the hip								
Eye Examination and cover/uncover test (Denver)								
Developmental Screening Test (Denver)								
Developmental Assessments								

IMMUNIZATION	BIRTH	1st week or 1st visit	2 - 4 weeks	2 months	4 months	6 months	9 months	12-15 months
Diphtheria Poliomyelitis Tetanus Pertussis								
Measles (Rubeola)								
Mumps								
Rubella								
BCG		3 - 5 Days						
Influenza						once/year		

COUNSELLING	BIRTH	1st week or 1st visit	2 - 4 weeks	2 months	4 months	6 months	9 months	12-15 months
Needs Assessment								
Parenting								
Accidents								
Nutrition								

LABORATORY INVESTIGATIONS	BIRTH	1st week or 1st visit	2 - 4 weeks	2 months	4 months	6 months	9 months	12-15 months
Testing of cord blood for congenital syphilis								
Testing of cord blood Coomb's Test hemoglobin & bilirubin concentrations								
Testing of cord blood for mercury								
Serologic testing for toxoplasmosis								
Serologic testing for syphilis			weekly					
Guthrie & Fluorometric tests for phenylketonuria		4 - 6 Days						
PKU urine card test								
Testing for hypothyroidism								
Determination of blood hemoglobin concentration					Once between 4 - 6 months			

CHILDREN (18 MONTHS - 16 YEARS)

HISTORY TAKING AND PHYSICAL EXAMINATION	18 Months	2 - 3 Years	4 Years	5 - 6 Years	10-11 Years	12-16 Years
Measurement of height and weight						
Complete physical assessment			← Once between 4 - 6 →			
Eye examination plus cover/uncover test		← Once between 2 - 4 →				
Vision Chart Test		← Once between 2 - 4 →		← ANNUALLY →		
Clinical Examination for Hearing						
Check for Retarded or Defective Speech						
Oral Examination for Dental Caries, Periodontal Disease	←		ANNUALLY			→
Developmental Screening Test (Denver)			← Once between 4 - 6 →			
Behaviour problems, Assessment of Parent Child Interaction			← Once between 4 - 6 →			
Scoliosis Screening					← Once between 11 - 12 yrs. →	

IMMUNIZATION	18 Months	2 - 3 Years	4 Years	5 - 6 Years	10-11 Years	12-16 Years
Diphtheria Tetanus Poliomyelitis			← Once between 4 - 6 →			
Pertussis			← Once between 4 - 6 →			
Rubella (Girls)					← Once between 11 - 12 →	
Influenza	←		ONCE PER YEAR			→

COUNSELLING	18 Months	2 - 3 Years	4 Years	5 - 6 Years	10-11 Years	12-16 Years
Needs Assessment						
Accidents						
Sexual Development						
Chemical Abuse						
Nutrition						
Hygiene: Personal and Oral						

LABORATORY INVESTIGATION	18 Months	2 - 3 Years	4 Years	5 - 6 Years	10-11 Years	12-16 Years
Determination of Blood Hemoglobin Concentration			← Once between 4 - 6 →			
Dental Roentgenography						
Papanicolaou Smear						+ second test one year after

ADULTS

HISTORY TAKING AND PHYSICAL EXAMINATION	16 19	20 24	25 29	30 34	35 39	40 44	45 49	50 54	55 59	60 64	65 69	70 74	75
Measurement of Blood Pressure													
Assessment of Hearing													
Measurement of Height & Weight													
Physical Examination for cancer of skin													
Physical Examination for cancer of breast	←							ANNUALLY					→
Physical Examination of Oral Cavity	←				ANNUALLY								→
Assessment of Physical, social & Psychologic function											← EVERY 2 YEARS		→

IMMUNIZATION	16 19	20 24	25 29	30 34	35 39	40 44	45 49	50 54	55 59	60 64	65 69	70 74	75
Poliomyelitis													
Tetanus													
Diphtheria													
Rubella (women)													
Influenza	←					ANNUALLY							→

COUNSELLING	16 19	20 24	25 29	30 34	35 39	40 44	45 49	50 54	55 59	60 64	65 69	70 74	75
Needs Assessment													
Oral Hygiene													
Chemical Abuse													
Accidents													
Marital family & sexual problems													
Nutrition													
Life Styles													
Breast self-examination	←			YEARLY INSTRUCTION IF NECESSARY									→

LABORATORY INVESTIGATION		16 19	20 24	25 29	30 34	35 39	40 44	45 49	50 54	55 59	60 64	65 69	70 74	75
Dental Roentgenography														
Determination of Blood Hemoglobin Concentration														
Testing of Stool for Occult Blood								←		ANNUALLY				→
Papanicolaou Smear	General	← EVERY 3 YEARS →				← EVERY 5 YEARS →								
	High Risk	←			ANNUALLY									→
Smear & Culture for Gonorrhea (cervix or urethra)														
Serologic test for syphilis														
Mammography								ANNUALLY						
Chest-X-Ray														
Testing for Mercury														

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Approved By: /

Number: III - 30

Date:

Category: Family Health Care Program

COMMUNICABLE DISEASE CONTROL

The communicable disease control program will be implemented in conjunction with the family health care program. Immunization schedules are specified in the periodic health assessment chart. Nurses will assess requirements for administration of additional immunizing agents with reference to Health and Welfare Canada's Guide to Immunization for Canadians and in consultation with the Medical Officer of Health. Each nurse will be responsible for:

-ensuring that his/her client families are familiar with the immunization schedule and promoting their participation;

-obtaining consents for immunization;

-monitoring of immunization levels and follow-ups of clients not up-to-date;

-planning and conducting regular immunization clinics in conjunction with other health staff;

-administering immunizing agents;

-monitoring for symptoms of communicable disease, preliminary diagnosis and referral to a physician as required;

-consultation with Medical Officer of Health as necessary;

-implementing physician prescribed patient care;

-contact tracing and follow-up;

-assisting attending physician in completing Province of Manitoba notifiable disease reports;

-participating in the development of annual reports including a narrative review and assessment of program delivery and a summary of community immunization status (see policy number) and the incidence of communicable diseases.

III-60

Approved By:✓ Number: III · 40

Date: Category: Family Health Care Program

HOME VISITS - NURSES

The successful implementation of the Family Health Care Program depends on the establishment of postive nurse—client family relationships. Regular home visits are essential to develop each relationship. Each nurse coming on staff will be assisted by community health representatives in initial orientation and introduction to assigned client families. Nurse will then be responsible for developing a home visitation plan based on records review, client consultation, needs assessment and iterative nursing plan of care process. Minimal standards for home visits are as follows:

- all families/households - home visits twice/year.
- newborns delivered in hospital - home visit within one week of hospital discharge for full physical examination and risk assessment.
- newborns delivered in nursing station - daily home visits for ten days following discharge from nursing station (see policy number). II · 50
- prenatals - home visit early in pregnancy for examination, nutritional assessment and risk assessment.
- postnatals - as per newborns, postnatal examination and needs assessment.
- patients discharged from hospital - home visit within one week of return to community.
- chronic and elderly - quarterly home visits.
- families in crisis (death, severe illness, family breakdown etc.) - as appropriate.

Approved By:

Number: IV-20

Date:

Category: Environmental/Occupational Health and Safety Program

WATER QUALITY MONITORING

A water sampling program will be implemented to monitor water quality. Samples for bacteriological analysis will be collected by Community Health Representatives weekly from the point where water enters the distribution system and from a representative sample (sample points are to be varied) of points along the distribution system. Samples for analysis of chemical characteristics will be collected semi-annually. All samples will be sent to the Cadham Provincial Laboratory in Winnipeg for analysis within 24 hours of collection. Copies of laboratory analysis reports will be forwarded to the Health Authority's consulting Public Health Inspector and Medical Officer of Health.

Approved By:

Date:

Number: IV-30

Category: Environmental/Occupational Health and Safety Program

PUBLIC HEALTH INSPECTION

A public health inspection program will be implemented to monitor public facilities, worksites and domestic living conditions. A qualified Pulbic Health Inspector will visit the community quarterly to assist Community Health Representatives in delivery of these services. A minimal schedule for inspections is as follows:

°Solid and Liquid Waste Collection and Disposal Systems
will be inspected bi-annually. Advice will be proveded on siting and construction of any new facilities

°Public Facilities
including the school, administrative offices, nursing station, child care facility, personal care home, pool hall, airport facilities and arena will be inspected bi-annually

°Food Outlets
including the restaurant, stores and kitchens of the child care facility and personal care home will be inspected quarterly

°Worksites
will be inspected annually

°Residences
will be inspected on request or at the direction of Chief and Council

Approved By:

Number: IV - 40

Date:

Category: Environmental/Occupational Health and Safety Program

HEALTH AND SAFETY PROMOTION

The major focus of the Environmental/Occupational Health and Safety Program and major priority for Community Health Representatives is health and safety promotion. Community Health Representatives are responsible for on-going assessment of community needs and identifying of priority topics and themes to be pursued through community education and organization of community activities.

Approved By:

Number:

Date:

Category: Alcohol and Drug Abuse Program

PROGRAM DELIVERY RESPONSIBILITIES

Substance Abuse Counsellors are responsible for delivery of the Alcohol and Drug Abuse Program which is to include primary, secondary and tertiary prevention and promotion activities. Counsellors are to participate fully in the health care work planning process and in particular to consult with nurses in coordinating delivery of family health care and alcohol and drug abuse services. Substance Abuse Counsellors are responsible for submitting quarterly reports on program activities and needs to the Health Care Administrator.

Approved By:

Number: V-20

Date:

Category: Alcohol and Drug Abuse Program

PROGRAM ACTIVITIES OUTLINE

Substance Abuse Counsellors are responsible for on-going assessment of community, family and individual needs and for priorizing and planning program activities to address those needs. The following provide a partial inventory of such program activities:

1) Primary prevention Activity - Taking action before serious problems start to develop. A primary prevention activity results in the community wide distribution of information. These activities are mainly intended to prevent initial abuse. The following activities are considered primary prevention activities:

   a) Public Awareness Campaigns - a specifically planned and organized information "blitz" in the community. This may include one or more of the other primary activities.

   b) Public Meetings - a scheduled meeting where the Substance Abuse Counsellor has invited the members of the community.

   c) Public Speaking - primary activity where a Substance Abuse Counsellor has been invited to speak at a gathering of community members.

   d) Develop School Curriculum - a primary activity where the Substance Abuse Counsellor has met with school officials to creat a component of the shcool's curriculum that deals with the abuses of alcohol, drugs, or solvents.

   e) School Program - a primary activity where the Substance Abuse Counsellor has assisted a school teacher in teaching the effects of alcohol, drug, or solvent abuse.

   f) News Media Work - a primary activity where television, radio, or newpapers (Band newsletter) is used to distribute information.

   g) Sponsor Spiritual Event - a spiritual event where the Substance Abuse Counsellor offers support of the event with the intention of making the community aware of the issues of abuse.

   h) Sponsor Cultural Event - a cultural event where the Substance Abuse Counsellor offers support of the event with the intention of making the community aware of the issues of abuse.

2) Secondary Prevention Activity - Early intervention: dealing with an existing abuse problem at the earliest possible stage. A program or event that offers an activity as an alternative to abuse is a secndary prevention activity. These activities are mainly intended to prevent abuse before it becomes a serious problem. The following activities are considered secondary prevention activities.

a) Recreational/Athletic - a program or event organized or sponsored by Substance Abuse Counsellors which is mainly recreational or athletic in nature.

b) Spiritual - a program or event organized or sponsored by Substance Abuse Counsellors which is mainly spiritual in nature.

c) Native Cultural - a program or event organized or sponsored by Substance Abuse Counsellors which is mainly cultural in nature.

d) Social - a program or event organized or sponsored by Substance Abuse Counsellors which is mainly a social gathering.

e) Other Group's Program - a program or event organized by another community organization in which Substance Abuse Counsellors particpate.

f) Discussion Groups - a program or event organized by the Substance Abuse Counsellors where community members meet to discuss any topic (not necessarily alcohol, drug, or solvent abuse).

3) Tertiary Prevention Activity - Maintenance: helping people to prevent a problem from returning. an activity that involves Substance Abuse Counsellors working directly with individuals, families, or groups to stop or prevent further abuse. The following activities are considered tertiary prevention activities:

a) Individual Counselling - a tertiary activity where a Substance Abuse Counsellor counsels an individual on a one-to-one basis.

b) Family Counselling - a tertiary activity where a Substance Abuse Counsellor counsels the family of a known or potential abuser.

c) Group Counselling - a tertiary activity where a Substance Abuse Counsellor counsels a group of known or potential abusers.

d) A.A. Group - a tertiary activity where a Substance Abuse Counsellor assists an Alcohol Anonymous organization with such activities as obtaining resource speakers, supervising meeting facilities, etc.

e) Alanon Group - a tertiary activity where a Substance Abuse Counsellor assists an Alanon organization with such activities as obtaining resource speakers, supervising meeting facilities, etc.

f) Alateen Group - a tertiary activity where a Substance Abuse Counsellor assists an Alateen organization with such activities as obtaining resource speakers, supervising meeting facilities, etc.

g) Crisis Intervention - a tertiary activity where a Substance Abuse Counsellor intervenes in a crisis situation because alcohol, drug or solvent abuse is involved.

h) Outreach Visits - a tertiary activity where a Substance Abuse Counsellor takes the initiative to make the first contact to an individual or family who could benefit from the prevention project's services.

i) Support Visits - a tertiary activity where a Substance Abuse Counsellor visits a known or potential abuser to reassure those involved.

j) Rehabilitation Referral - a tertiary activity where a Substance Abuse Counsellor refers an abuser to a rehabilitation centre or program.

k) Detox Referral - a tertiary activity where a Substance Abuse Counsellor refers an abuser to a medical Detox centre.

l) Medical Referral - a tertiary activity where a Substance Abuse Counsellor refers an abuser to a doctor or hospital for medical services.

m) Social Service Referral - a tertiary activity where a Substance Abuse Counsellor refers an abuser to a beneficial service offered by the Band.

n) Band Service Referral - a tertiary activity where a Substance Abuse Counsellor refers an abuser to a beneficial service offered by the Band.

o) Cultural Referral - a tertiary activity where a Substance Abuse Counsellor refers an abuser to a native cultural support group or person (elder).

Approved By:

Date:

Number: VI-10

Catetory: Community Health Promotion

PROGRAM DELIVERY RESPONSIBILITY

Through the staff work planning process the health care team will be involved in identifying "hot spots" for community health promotion. Hot spots would include areas such as accident prevention, nutrition education, community sanitation, mental health awareness or family planning. Team members are responsible for targeting such areas for concerted team effort and developing and implementing strategies for effective intervention.

Approved By:

Date:

Number VII -10

Category: Work Planning

WORK PLANNING PROCESS

The health care program has been designed to combine the benefits of team work with those of complimentary specialties. Each member of the health team has been assigned lead program responsibilities in certain areas.

- °nurses - primary care treatment services, family health care
- °community health representatives - health and safety surveillance and promotion
- °substance abuse counsellors - alcohol and drug abuse prevention
- °consulting specialists - professional specialties
- °clerk - office management and referrals
- °maintenance/housekeeping - facilities and equipment upkeep
- °health care administrator - program management

The forum for coordination and team building will be weekly staff meetings. Team members will come to these meetings knowing their priorities for the coming week in their respective areas of responsibility and having identified areas requiring cooperative action. Under the direction of the Health Care Administrator the team will develop and negotiate a coordinated work plan to make efficient use of staff resources in meeting community needs.

Approved By:

Date:

Number: VIII - 10

Category: Referrals

MEDICAL SERVICES BRANCH REFERRAL PROCEDURE

Nurses, Substance Abuse Counsellors, Consulting Physicians and Dentists are authorized to refer patients to outside medical and treatment facilities in accordance with Medical Services Branch Regional Guideline Number 1-4 (attached). Medical Service Branch will be responsible for all associated costs.

REGIONAL GUIDELINES

MANITOBA REGION
MEDICAL SERVICES BRANCH
NATIONAL HEALTH AND WELFARE

INITIATOR:
RESPONSIBILITY: ADMINISTRATION
SIGNATURE: _____
APPROVAL _____

SECTION: 1
GUIDELINE: 4
ORIG. DATE: VARIOUS
LAST REV. DATE: 860401

1-4 PATIENT REFERRALS:
A) GENERAL
B) ESCORTS
C) BAND/SELF REFERRALS
D) NNADAP REFERRALS
E) ORTHODONTIC TREATMENT REFERRAL
F) REFERRALS TO TRADITIONAL HEALERS

This guideline contains all current information relative to Patient Referrals.

Please be reminded that all referrals occur in a similar manner, and only those requiring other arrangements, details, or direction are broken out into sub-groups (i.e. Patient Referral - Traditional Healers).

A. GENERAL

A medical decision to refer a patient is made by a Nurse in Charge, and should be made in consultation with a doctor whenever possible. Charters may be utilized when the use of scheduled flights might compromise the patient's health/medical status or when it's more cost effective.

Nurses at Nursing Stations are authorized to refer patients requiring care that nurses and visiting doctors are unable to provide, to the nearest medical facility capable of supplying the treatment required.

There are no financial restraints or financial considerations relevant to the decision to evacuate/refer or not evacuate/refer a patient. Neither should community leaders or the community at large be led to believe that this is so. Notwithstanding this, evacuations should be made in an efficient way, in respect to both time and financial resources. At no time, however, should this consideration affect arrangements when health status is compromised.

Nurses are directed to arrange for evacuations from fish camps or traplines to Nursing Stations on the basis of information available from the source or from an informer. Please err on the side of caution. Should there arise an occasion when, in the judgement of nursing staff, the request for evacuation has been frivolous or abusive in its intent, this should be reported in writing simultaneously to the Zone Director and Chief and Council of the local community, including all relevant information. Action deemed necessary will be taken by Zone management in conjunction with community leadership.

All referrals must be coordinated through the Nursing Station.

All referrals to Winnipeg must also be coordinated through the Referral Unit in Regional Office. All referrals to Thompson must also be coordinated through the Referral Unit in North Zone Office.

Basic Patient Referral Procedure

1. Nurse identifies a patient requiring medical services not available in the community. Whenever possible this is done in consultation with a doctor.

2. Nurse requests referral in writing from appropriate referral unit by completing Request for Appointment Section of the Referral Request and Reply Form (see attached example); nurse mails form to appropriate referral unit, and awaits confirmation. In urgent cases, the nurse will telephone request for appointment information.

3. Referral Clerk confirms arrangements with nurse, verbally if possible, and records confirmation on Reply Section of Referral Request and Reply Form. Copy of Reply is mailed to nurse in all cases.

4. Nurse notifies the patient (and escort if applicable) of arrangements made; nurse completes Case History and Consent form (see attached example), and explains the following to the patient and/or guardian:

   a) Consent for treatment, boarding care, release of medical treatment.
   b) Necessity of clothing and personal effects.
   c) Responsibility of escort.
   d) Accommodations and boarding procedures, ascertaining preference of patient.

Arrangments should be made for other treatment (e.g. dental, glasses) if required, and not available in respective area.

5. Field clerk arranges transportation, completes one-way travel warrant and taxi vouchers and gathers information that will be accompanying patient. Escort (or patient) should be informed of phone numbers for, and location of, applicable referral unit.

6. Nurse authorizes referral by signing warrant after ensuring information is complete and patient (and escort) are prepared for referral out.

7. Escort delivers patient to destination and contacts referral clerk for further instructions and/or warrant. Escorts will normally return by next available flight with any returning patients.

8. Referral clerk confirms arrival of patient and escort by:

   a) Receiving calls from patient and/or escort or boarding home operators

   or

   b) Calling patient or boarding home operator when this information is not received.

9. Referral clerk arranges for local transportation of patient, necessary escort/interpretor, and the provision of other medical supplies and services for the patient, e.g. prosthetic devices, glasses, dentures. Note: Referral clerk will contact field nurse for authorization of any additional medical services that are found to be necessary while the patient is in referral centres e.g. glasses, dental care.

10. Boarding home operators, doctors' offices, and hospitals advise referral clerk of any follow-up appointments or anticipated repatriation date. If no report is received, referral clerk follows up.

11. Progress reports on patients are provided by the referral clerk to field units twice weekly; any significant changes will be reported immediately.

12. Referral clerk arranges for boarding and foster home placement of patients on discharge from hospital and records same; reports change of status and whereabouts of patients to respective field units.

13. Referral Clerk arranges for patient's transportation home, completes and authorizes travel warrant and taxi vouchers, and arranges for patient to receive same.

14. Referral clerk advises field unit of patient's return, follow-up appointments and any other special instructions; arranges for necessary escort services.

B. ESCORTS

Once the Nurse in Charge has made a decision to refer the patient, it will be determined if an escort is required. In most instances escorts should be used for the following:

a) Children between the ages of 12 and 18 if, in the judgement of either nurses or family members, this is desirable for reasons related to child safety or parental involvement in the child's treatment.

b) Children under the age of 12.

c) Disabled, e.g. blind, crippled, senile and very elderly people.

d) Critically ill patients, who would, of course, be accompanied by the closest relative available.

e) For mental health reasons.

Selection of Escorts

If the Nurse in Charge determines that an escort is required, the following criteria (in order of priority) should be used when choosing an escort:

a) A family member who is required at the treatment centre to provide a patient history.

b) Medical Services personnel who happen to be travelling in the same direction on duty.

c) A family member who volunteers to escort the patient.

d) A reliable member of the community who is capable of escorting the patient.

The Chief and Council or the Health Committee are available to recommend individuals for escort duty.

NOTE: All escorts must be competent individuals over the age of 18.

f) Other responsible individuals travelling to the treatment centre.

Medical Services Branch will assume responsibility for escort's travel. Nurses are free to arrange for escorts on compassionate or humanitarian grounds on a limited basis, e.g., where trauma to the family or patient is abundantly evident and where attendance by a family member is considered to be directly relevant to the outcome of procedures taking place elsewhere, (e.g. operative). The number of family escorts in these cases will be one only. Additional requests from the family or from community members should be referred to the Department of Indian and Northern Affairs.

C. BAND/SELF REFERRAL OF PATIENT

Where referral of patient is insisted upon by the individual, a Chief, or a Council member, against the advice of the nurse or doctor, the nurse will arrange for the referral under the following conditions:

a) All referrals must be coordinated through the Medical Services health facility and the respective referral units.

b) The Referral Unit in the referring centre will assist the patient by arranging appointments as required; transportation and accommodation is the responsibility of the individual concerned.

c) Transportation costs from the home community to and from the referral centre will be paid by the individual or the Band.

d) The Nurse in Charge will notify the Zone Director in writing of the circumstances of each specific case.

e) Where justification for referral from the home community can be established by the individual on presentation to the Zone Director, Medical Services will reimburse the Band or the individual for the transportation (mentioned in (d) above) and accommodation costs in accordance with our current boarding home fee schedule.

f) In cases where justification of referral cannot be established, no reimbursement for transportation or accommodation will be made to the Band or the individual.

g) Self-referred patients who request assistance while in referral centres should be referred to the local Indian Affairs Branch Office.

Where a client has initiated his/her own or a family appointment directly with a medical practitioner or hospital, all transportation and accommodation charges are the responsibility of the individual.

Medical Services Branch will reimburse clients in the following instance:

- When justification for referral from the home community is presented to the Zone Director, and upon his/her approval, Medical Services will reimburse the individual for the transportation and accommodation costs in accordance with our current boarding home fee schedule.

An exception to the above is applicable in cases where the Medical Services Branch Referral Unit or Nursing Station is a) notified of the appointment a minimum of two working days prior to the appointment, b) the appointment is justified and verified with the physician. The appointment is then handled as a normal referral.

D. NATIONAL NATIVE ALCOHOL AND DRUG ABUSE PROGRAM (NNADAP) REFERRALS

All NNADAP patients referred to Treatment Centres for the treatment of alcoholism will be provided transportation by Medical Services Branch warrant. The following procedures must be followed to ensure that the patient is transferred with as much ease as possible while at the same time ensuring that financial requirements are met:

a) Project coordinators will make referrals, in criting,ors the nearest Medical Services Branch. Warrant issuing authority (Nursing Station, etc.).

b) Where Medical Services Branch warrant issuing authority is not available, NNADAP Consultants will be contacted to make other arrangements.

c) In locales where there are no Project Coordinators, the Band Administrators or Councillors, in consultation with a Zone NNADAP Consultant, will make the appropriate referral arrangements and the Counsultant will request a warrant from the warrent issuing authority in writing.

Warrents will be issued one-way only. Return transportation will be provided by Medical Services Branch Referral Units upon receipt of notification from the Treatment Centre that the patient is being discharged.

Agencies issuing warrants for travel to Treatment Centres will notify Referral Units at the treatment location to facilitiate return transportation at the appropriate time.

All warrants must show "NNADAP Patient Treatment" in the "purpose of travel" section.

Re-referral is disallowed if a client returns to the community base without approval of the treatment centre unless a suitable period (e.g. 2-4 weeks) passes and the NNADAP Co-ordinator assures the intent to re-enter and complete therapy.

E. ORTHODONTIC TREATMENT REFERRAL

Patients referred by a dentist to a specialist for ongoing Orthodontic Treatment will be handled the same as other referrals and at our cost.

Patients self-referring for Orthodontic care fall outside of our guidelines and their costs will not be supported.

F. PATIENT REFERRAL - TRADITIONAL HEALERS

When it is determined that it is appropriate for a patient to be referred to a recognized "traditional healer", we should attempt for facilitate such a referral in the same manner we would use to any health professional. That is, we would either arrange for the traditional healer to be brought to the patient or vice versa.

Requests for arrangements for treaty patients to attend traditional healers should be made to the Zone Director. Requests should include the complaint for which remedy is sought, who will travel, geographical location of traditional healer, and exact costs in return transportation. Approval of the Zone Director to the patient is required in writing prior to travel in order for Medical Services Branch to assume financial responsibility. In cases where approval is not sought, we would regard the referral as a "self-referral", making reimbursements as appropriate.

As is in the case of all referrals for which Medical Services is accepting the financial responsibility, original copies of authorizations, invoices and other proofs of payment are required in support of payment. Only the most economical and reasonable travel costs will be accepted. Treasury Board travel rates and regulations will not be exceeded. Incidental expenses are not payable since travellers are not on government business (as for patients in transit). Travel to the U.S.A. should be discouraged and use made of traditional healers located in Canada.

Should you require additional information relative to patient referrals please contact the appropriate Zone Director, or Referral Services Administrator (Region or North Zone).

MEDICAL SERVICES BRANCH, HEALTH & WELFARE PATIENT REFERRAL FORM AND TRANSIT NOTES

Complete as fully as possible and should accompany every patient being referred. Original of page 1 & 2 accompany patient. Copies of pages 1 & for patient file. If care is given during evacuation both copies should be carried on route and copy returned to patient file.

Field Unit _____ Referred by _____

Date and Time of Evacuation _____ Emergency _____ Elective _____

SECTION A: PATIENT IDENTIFICATION M.H.S.C. # _____

DATE OF BIRTH	SEX	MARITAL STATUS

NAME: _____

BAND NO. & NAME (if applicable) _____ RELIGION _____

PRESENT ADDRESS OF PATIENT: _____

NAME OF PARENT, GUARDIAN OR NEXT OF KIN _____

ADDRESS & PHONE NUMBER OF PARENT, GUARDIAN OR NEXT OF KIN _____

NAME OF EMPLOYER _____ OCCUPATION _____
(If patient is wife or child, state name of husband's or father's employer and his occupation)

Is this a W.C.B. case? _____ Has employer, employee and initial treatment officer completed W.C.B. forms? _____

SECTION B: TRANSPORTATION INFORMATION

Mode of transportation: ☐ Train ☐ Bus ☐ Taxi ☐ Plane ☐ Private Car

From _____ If travel by plane ☐ scheduled flight
☐ split charter
☐ exclusive charter

Referred to _____ (Specify hospital or doctor & address)

SECTION C: CONSENT FOR TREATMENT, BOARDING HOME CARE, RELEASE OF INFORMATION, ETC.

I hereby authorize the attending physician and hospital staff in charge of the above named patient to carry out any form of examination, tests, treatment, and to administer such medications as they may consider advisable in the diagnosis and treatment of this patient.

I understand and appreciate that no guarantee can be given as to the results of such measures and accept the normal risk of complications or side effects.

I also authorize the attending physician to arrange placement of this patient in another hospital or a suitable boarding home while undergoing investigation, treatment or follow-up of his/her disease or condition.

I also authorize release of information on these patient referral forms to medical professionals as required for treatment purposes, and to referral unit for social coordination.

WITNESS: (two witnesses must sign if Parent or Guardian signs with an "X" otherwise one witness required)

_____
Parent or Guardian

_____
Witness

_____
Relationship

_____
ness

Date _____ Time _____ a.m. p.m.

I certify that I have fully explained to the Parent or Guardian in the presence of the witnesses the details of the above consent.

Signature of Nurse or Community Health Representative _____

D-S-86

PATIENT REFERRAL FORM AND TRANSIT NOTES

SECTION D: MEDICAL INFORMATION

NAME _____ BAND NO. _____ SEX _____

Band and/or Address _____ AGE _____

Presenting Complaint _____

HISTORY PAST. PRESENT for patient and family — include previous referral

ALLERGIES

PHYSICAL FINDINGS

ROVISIONAL DIAGNOSIS

Who was consulted regarding referral? _____ Escort Type _____

Treatment given prior to evacuation _____

reatment given during evacuation (Emergency Evacuation only) _____

ECTION E: IMMUNIZATION HISTORY

	Diphtheria	Pertussis	Tetanus	Polio	Rubeola	Rubella	B.C.G.	Other
1st dose								
2nd dose								
3rd dose								
4th dose								
5th dose								

te and Reaction to last Tuberculin Test _____

positive, date of conversion (if known) _____

te _____ Signature _____

ss

REFERRAL REQUEST AND REPLY FORM

REQUEST

TO: Referral Unit

_____

_____

FROM: Nurse-in-Charge

_____

_____

Name of Patient: _____

Birth Date: _____

Band & Band #: _____

M.H.S.C. #: _____

Residence: _____

Services Required: (Please Check)

- Escort ( )
- Boarding Home ( )
- Foster Home ( )
- Any Additional ( )
- Interpreter: Cree ( )
  - Sioux ( )
  - Saulteaux ( )
  - Other (specify)

Date Referral Requested: _____

Requested by: _____

Referred by: _____

Refer to: _____

Suggested Appt. Date: _____

Diagnosis & Relevant Information:

_____

_____

_____

_____

_____

_____

_____

Signature:

_____

REPLY

TO: Nurse-in-Charge

_____

_____

FROM: Referral Unit

_____

_____

NAME, BAND, TREATY #: _____

DATE & TIME OF APPOINTMENT: _____

PLACE: _____

DOCTOR: _____

SERVICES REQUIRED HAVE BEEN NOTED: _____

SPECIAL INSTRUCTIONS _____

_____

_____

DATE REPLY PHONED: _____

DATE REPLY MAILED: _____

Signature _____

Approved By:

Date:

Number: IX -10

Category: Patient Consent

CONSENT TO TREATMENT OR IMMUNIZATION

Health care staff and contract personnel will obtain the written consent of patients or the parents or legal guardians of patients prior to providing treatment services or administering immunizing agents. The only exceptions to this rule would be in circumstances where a patient is in an emergency condition and physically or mentally incapable of giving consent, or when delaying treatment to obtain parent or guardian consent would endanger the patient.

Consent forms for immunization are incorporated in the personal health record forms filed in the community health files (see Health Records Policy Number). Consent to treatment forms are attached. These will be filed with Treatment Charts, Z

Generally, patient consent will be obtained only for services to be provided in the community by Health Authority staff or contract personnel. Consent for services provided outside the community (e.g. The Pas Hospital) are to be obtained by the providers. The exception to this rule would be a circumstance where a minor is to be referred for treatment but not accompanied by a parent or legal guardian. In such a case Health Authority staff will obtain the written consent of parents or guardians on the Patient Referral Form and Transit Notes (see Referral Policy number). VIII -10

Principles of Valid Consent

1. The consent must be voluntary.

2. The patient, parent or guardian must be told the nature and risk of the treatment, of not having the treatment and any alternative treatments.

3. The patient, parent or guardian must have the mental capability to understand the nature and risks of the proposed treatment.

4. The patient, parent or guardian must consent to the treatment actually performed.

5. There is no legal age or consent. Discretion must be used in recognizing the capacity of mature minors to consent to treatment.

FIRST NATION HEALTH AUTHORITY

CONSENT TO TREATMENT FORM

I hereby authorize the nursing staff or attending physician of the First Nation Health Authority to carry out any form of examination, test or treatment, and to administer such medications as they may consider advisable in diagnosis and treatment.

I understand and appreciate that no guarantee can be given as to the results of such measures and accept the normal risk of complications or side effects.

Patients Name

Signature of Patient, Parent or Guardian

Witness

Relationship of Signator to Patient

Witness

Date: Time: a.m.

I certify that I have fully explained to the patient, parent or guardian the details of the above consent.

Nurse/Physician's Signature

Position

DATE: Time: a.m. p.m.

Approved By:

Date:

Number: IX-20

Category: Patient Consent

LEGAL REQUIREMENTS FOR TAKING OF BLOOD AND OTHER SPECIMENS

1.a) Where a police officer believes, on reasonable and probable grounds, that a person was operating a motor vehicle, vessel, or aircraft within the preceeding two hours the officer may demand that a qualified physician take a blood sample. The test must be done by a qualified physician, or under his or her direction. The qualified physician must be satisfied that the taking of such samples would not endanger the life or health of the person being tested.

b) A Judge/Magistrate/J.P. may issue a warrant authorizing a police officer to require a physician, or a nurse/laboratory technician under the direction of a physician, to take a blood sample. This warrant requires belief that the person has been involved in an accident resulting in death or bodily harm to any person. The physician must be satisfied that the taking of the samples would not endanger the life or health of the person being tested. The physician must also be satisfied that the person being tested is unable to give informed consent to the taking of the blood samples.

c) Where a physician registered nurse, or qualified laboratory technician has reasonable and probable grounds to believe that a person whom they are treating or making laboratory tests on, or who has been brought to them for treatment or for the purpose of making laboratory tests, "has within the preceding two hours been driving a motor vehicle or been navigating or operating a vessel", they may, without the consent of the person where that consent cannot be obtained, and without using compulsion, take a

sample of the person's blood and analyze it or cause it to be analyzed for alcohol or drug content. They must be satisfied that the taking of the sample would not endanger the life or health of the person being treated.

Neither the practitioner, nor the person who analyzed the specimen, nor the owner of the hospital, clinic or laboratory is thereby liable for any damages to the person from whom the sample of blood was taken, except damages arising on a negligence procedure used to take the sample of blood.

Where a physician, registered nurse or laboratory technician has taken a sample of blood and analyzed it, or caused it to be analyzed for alcohol or drug content, the name of the person from whom the sample was taken and results of the analysis may be disclosed to a police officer or a court and in that case neither the physician, nurse, laboratory technician or the person who analyzed the sample of blood nor the agencies are liable for any damages arising out of the disclosure.

2. Excluding blood samples, no other specimens shall be taken from a patient without first receiving either a court order or an informed consent from the patient. The consent given by the patient must be free, genuine and voluntary. The patient must have the opportunity to choose between consent and refusal without fear, constraint, compulsion or duress. Consent obtained under compulsion, duress or by misrepresentation is invalid. A consent obtained from a patient under the influence of alcohol or following the giving of a sedative may be held invalid.

3. If a patient has consented to treatment by a physician who orders tests in order to assist with the diagnosis and treatment of the patient's condition, the tests may be completed and the results filed on the patient's chart. The information regarding these tests may not be released to other than the physician unless ordered by the court.

4. The taking of body fluid samples for alcohol and drugs from cadavers is at the discretion of the nurses. Refusal to take such samples does not constitute an infraction under the law.

Approved By:

Number: X-20

Date:

Category: Health Records

RELEASE OF MEDICAL CONFIDENTIAL INFORMATION: STATEMENTS TO POLICE

1. The release of Medical Confidential Information to a police officer must be documented by completion by the R.C.M.P. of an Authorization for Release of Medical Confidential Information Form. This Authorization should be signed by the patient or legal guardian in the presence of the same witness.

2. Confidential medical information relating to a patient shall be provided to the court when the Health Authority is subpeonaed. On receipt of such a subpeona the Health Care Administrator shall notify the Board of Directors and act according to their instructions.

3. On the request of a police officer an employee may provide a statement that shall include only the facts relating to an incident and not include personal opinions, the patient's condition or the diagnosis, except where these are plainly obvious to any observers. Examples of obvious conditions are "the patient had cuts or abrasions" or "the patient had a broken arm".

DATE: _____

AUTHORIZATION FOR RELEASE OF MEDICAL CONFIDENTIAL INFORMATION

TO: _____
(hospital, clinic, doctor)

I, _____ the undersigned hereby authorize and direct you to furnish information on or before _____,(date) regarding medical attention received by _____
(name patient)
as a result of an incident occuring on _____
(date of incident)
to any person acting on behalf of the Royal Canadian Mounted Police. I understand that the information that is being furnished by you may be used by police for the purpose of prosecuting any charges which may arise as a result of the incident and I also understand that information may be disclosed at the trial of those charges. You, _____
(hospital, clinic, doctor)
are hereby released from any liability that may arise from the release of the information as requested.

DATE: _____ SIGNED: _____

I, _____, a _____, witnessed
(state name) (state occupation)
_____ sign this Authorization for Release of
(patient or next of kin)
Information on the _____ day of _____, A.D. 198_, and am satisfied that the said _____ fully understands the
(patient or next of kin)
meaning of the said Authorization and voluntarily consents to the release of the information specified herein.

SIGNED: _____ SIGNED: _____
(witness) Interpreter (if applicable)

DATE: _____ DATE: _____

Approved By:

Date:

Number: X-30

Category: Health Records

TREATMENT CHARTS

Forms - Type and Use

The following forms are maintained in file folders called treatment charts. Every client will have a separate chart.

1. Client Record

   This form should be used for:

   -Clinic visit for initial treatment or follow-up or treatment.

   -Home visit where the visit was made to do a treatment or follow-up on treatment.

   -Phone call received during which counselling was done on treatment, or follow-up for treatment.

2. Inpatient Notes

   Inpatient notes are to be maintained for all clients who are admitted to the Nursing Station for:

   -observation
   -nursing care
   -stabilization and maintenance prior to transfer to another facility or discharge home.

   Inpatient notes must include doctors consultations and orders if these are obtained.

   Physicians on site must chart on these forms.

   Do not repeat information recorded on other forms, but make reference to this information.

3. Patient Referral Forms and Transit Notes

   These forms are used at any time a referral is made to another receiving centre.

4. Problem List

   The problem list is used to ensure all identified problems have received appropriate care and attention. It provides each patient chart with a continuing summary of active and resolved problems.

5. Long Term Drug Profile

   This form is used to indicate drugs that are provided on a continuous basis. Recording of prescribing and dispensing is done on the client record.

Organization of Treatment Chart

1. File Folder will be: 14 3/4 x 9 1/2
   Left Hand Tabs
   Acco fasteners on each side of folder inside at the top.

2. Outside

   a) Label - A typed label will be attached to the left hand tab on outside of folder. It will be set up using LAST NAME (in capitals), first name and initial, Band Number and date of birth.

   b) Allergies - These are placed in large red block letters on face of folder.

   c) M.H.S.C. Number - To be written on face of folder.

3. Attachments to right side of folder

   a) X-ray reports - fastened by self adhesive side to file folder.

   b) Client records on top in chronological order with the most recent on top. These are attached to the folder with ACCO fasteners.

4. Attachments to left side of folder

   a) Problem lists uppermost.

   b) Drug profile immediately below problem lists(s).

   c) All other records (including patient referral and transit forms discharge letters) filed in ascending order.

FILING OF TREATMENT CHARTS

Treatment charts should be filed in the following manner:

   a) Alphabetical order by surname

   b) Band number order under each surname

   c) Where more than one person has the same surname and Band number place in alphabetical order by first name. Labels should indicate "NT" for non-treaty.

Manitoba Region

CLIENT RECORD – SIDE I

Surname	Given Names	Band No. and Band
Address	Phone No.	Next-of-Kin
Sex / Date of Birth	Religion	Allergies

Date Yr / Mo / Day	Time	Location of Service	ACTIVITY NOTES AND SIGNATURE

Health and Welfare Canada
Medical Services Branch
Manitoba Region

LONG TERM DRUG PROFILE – SIDE 1

Surname		Given Names	Band No. and Band
Address		Phone No.	Next-of-Kin
Sex	Date of Birth	Religion	Allergies

Date Commenced	Drug	Dosage	Signature of MD/RN	Date Discontinued	Signature of MD/RN

F-6-85

Services Branch
Region

PROBLEM LIST – SIDE I

me	Given Names	Band No. and Band
s	Phone No.	Next-of-Kin
Date of Birth	Religion	Allergies

ate ered	Problem	*Date Resolved	Recurrences Year/Month									

*hen you "cure" the disease not when you control the disease.

Medical Services Branch
Manitoba Region

INPATIENT NOTES – SIDE I

Name	Given Names	Band No. and Band
Address	Phone No.	Next-of-Kin

Sex	Date of Birth	Religion	Admission Date	Discharge Date

Date Yr / Mo / Day	TIME	ACTIVITY NOTES AND SIGNATURE

Approved By:

Number: F-40

Date:

Category: Health Records

FAMILY HEALTH CHARTS

Forms - Type and Use

The following forms are maintained in a file folder called Family Health Charts. This folder contains within it all individual Personal Health Records of "family" members living in a household. When an individual reaches 18 years of age and/or receives his own Band number, a separate family folder should be created. This should be noted on the parents' family folder.

1. Personal Health Records

   Each family member will have a "Personal Health Record". This record has been developed to be compatible with the Periodic Health Assessment Chart. This record is set up so that it can be used as a tool for assessment, planning, implementation and evaluation of an individual's total health care. Immunization records are to be maintained on this record. The consent form portion is to be completed and is part of the record.

2. Activity Notes

   The Personal Health Record contains one page of activity notes. Additional notes can be attached when needed.

   Activity notes should expand or clarify data identified within the Personal Health Record.

3. Withdrawal and Transfer Card

   This is to be used when records are transferred or moved somewhere else within the health centre filing system.

4. Other Records within Personal Health Records:

   a) DDST: Once the child reaches 7 years of age, these no longer need to be maintained within this file. A brief summary of the DDST should be recorded in the Activity Notes for permanent reference.

   b) GROWTH CHARTS:
   The same applies to these charts. Once complete and noted in Activity Notes they can be destroyed.

   c) PRENATAL FORMS:
   The same applies to these forms. Once complete and noted in Activity Notes they can be destroyed.

Filing of Community Charts

Charts should be maintained separately from Treatment Charts and filed in the following manner:

a) Alphabetical order by surname

b) Band Number order under each surname

OTHER MEMBERS OF HOUSEHOLD

Head of Household and Family Members	Relation to head	Date of Birth (give name of month)			Location of Client Record If not included
		Year	Month	Day	

FAMILY ENVIRONMENT (use pencil and update as required)

No. of Persons in Household: _____ Bathroom Facilities: _____

Living Space (No. of Rooms) _____ Sewage Disposal _____

No. of Sleeping Spaces _____ Garbage Disposal _____

Hydro _____ Food Storage: _____

Water Supply: _____ Heating (type) _____

Hazards: _____

PHYSICIAN'S NAME (pencil) _____ LOCATION _____ PHONE NO. _____

If other side if OTHER individuals live in household

Head of Household and Family Members (same band number)	Relation to head	Date of Birth (give name of month)			Location of Client Record If not included
		Year	Month	Day	

HOME PHONE NUMBER _____

FAMILY FOLDER

SURNAME _____ GIVEN _____

BAND NUMBER AND NAME _____

PERSONAL HEALTH RECORD
MANITOBA REGION

SURNAME	GIVEN NAME	BAND NO. AND BAND
ADDRESS	PHONE NO.	NEXT OF KIN
SEX / DATE OF BIRTH		MOTHER'S NAME
FAMILY PHYSICIAN (NAME AND PHONE NO.)		FATHER'S NAME
FAMILY PHYSICIAN (ADDRESS)		

FAMILY HISTORY (Identify relationship)

☐ CARDIAC DISEASE _____ ☐ DEAFNESS _____ ☐ OBESITY _____ ☐ CONGENITAL ABNORMALITIES _____

☐ HYPERTENSION _____ ☐ BLINDNESS _____ ☐ EPILEPSY _____ ☐ MULTIPLE BIRTHS _____

☐ DIABETES _____ ☐ T.B. _____ ☐ CIRCULATORY DISEASE _____ ☐ MENTAL RETARDATION _____

☐ CHEMICAL ABUSE _____ ☐ CANCER _____ ☐ OTHER (Specify) _____

BIRTH HISTORY

AGE OF MOTHER AT CONFINEMENT _____ GRAVIDA _____ PARA _____

PRENATAL CARE: ☐ INADEQUATE ☐ UNKNOWN ☐ CLASSES: _____

ADVERSE LIFESTYLES FACTORS _____

LABOR: ☐ SPONTANEOUS ☐ INDUCED DURATION: STAGE I _____ STAGE II _____ STAGE III _____

DELIVERY: TYPE _____ BIRTH WT. (gms) _____ LENGTH _____ HEAD CIRC. _____

DELIVERED IN: ☐ HOSPITAL ☐ NURSING STATION ☐ OTHER: _____

APGAR SCORE: 1 min. _____ 5 min. _____ 10 min. _____

COMPLICATIONS: PREGNANCY _____ DELIVERY _____ ABNORMALITIES _____

LENGTH OF PREGNANCY: _____

NEO-NATAL (0 - 28 days)

BREAST FED (Length) _____ BOTTLE FED (type) _____

AT RISK (Criteria) _____

CONSENT FOR IMMUNIZATION

Name _____ Date of Birth _____ (Yr./Mo/Day)

Parent or Guardian _____

I consent that the above named be given Immunization against those diseases checked below:

☐ Measles ☐ Mumps ☐ Rubella
☐ Diptheria ☐ Tetanus ☐ Poliomyelitis
☐ Pertussis ☐ BCG ☐ Other _____

_____ Date _____ Signature of Parent or Guardian

I certify that I have fully explained the above consent

_____ Date _____ Signature of Health Professional

BIOLOGICAL	DATE	SIGN.	DATE	SIGN.	DATE	SIGN.
BCG						

IMMUNIZATION: CONTRAINDICATIONS _____

BIOLOGICAL	DATE	SIGN.	DATE	SIGN.	DATE	SIGN.
Diphtheria						
Pertussis						
Tetanus						
Polio						
Rubeola						
Mumps						
Rubella						
Other (Specify)						
Other (Specify)						

es No Defect/Normal — ✓ Observation — O Referral — R Counselled — C

'ANTS (BIRTH – 17 MONTHS)	DATE							
'RY TAKING AND PHYSICAL EXAMINATION	AGE							
mplete physical assessment								
nical examination of cardiac murmurs								
asurement of length, wt. & head circumference								
amination for dislocation of hip								
e examination and cover/uncover test								
velopmental Screening Test (Denver)								
velopmental Assessments								
termination of blood hemoglobin concentration								
SIGNATURE								

OUNSELLING	DATE							
	AGE							
leeds Assessment								
arenting								
ccidents								
lutrition								
Other (Specify)								
Other (Specify)								
SIGNATURE								

CHILDREN (18 MONTHS -16 YEARS)	DATE							
HISTORY TAKING AND PHYSICAL EXAMINATION	AGE							
Measurement of height and weight								
Complete physical assessment								
Eye examination plus cover/uncover test								
Vision Chart Test								
Clinical Examination for Hearing								
Check for Retarded or Defective Speech								
Oral Exam for Dental Caries: Periodontal Disease								
Developmental Screening Test (Denver)								
Behaviour problems, Parent Child Interaction								
Scoliosis Screening								
Determination of Blood Hemoglobin Concentration								
SIGNATURE								

COUNSELLING	DATE							
	AGE							
Needs Assessment								
Accidents								
xual Development								
Chemical Abuse								
Nutrition								
Hygiene: Personal and Oral								
SIGNATURE								

ULTS	DATE						
TORY TAKING AND PHYSICAL EXAMINATION	AGE (YRS.)						
asurement of Blood Pressure							
irement of Height and Weight							
sical Examination for Cancer of Skin							
sical Examination for Cancer of Breast							
sical Examination of Oral Cavity							
sessment of Physical, Social & Psychological function							
er (Specify)							
er (Specify)							
	SIGNATURE						

	DATE								
UNSELLING	AGE (YRS.)								
ds Assessment									
l Hygiene									
mical Abuse									
dents									
ital family & Sexual Problems									
rition									
tyles									
ast Self-Examination									
	SIGNATURE								

ENATAL	PREGNANCY #								
UNSELLING	DATE								
ds Assessment									
rition									
astfeeding									
stinence from Smoking									
ohol Consumption: Chemical Abuse									
nily Planning									
st Partum Depression									
enting									
(Specify)									
er (Specify)									
er (Specify)									
	SIGNATURE								

NAME: GIVEN NAME: PAGE

DATE YR / MO / DAY	TIME	LOCATION OF SERVICE	ACTIVITY NOTES	SIGNATURE

NE | ADDRESS | PHONE

CTOR | HOSPITAL | INSURANCE-M.H.S.C.

NURSES | PILL | L.M.M.P. | E.D.C.

☐ 35 YEARS OR GREATER - AMNIOCENTESIS ☐ DONE ☐ NOT DONE ☐ REFUSED

BSTETRICAL | GRAV. | PARA | ALIVE

{ ALIVE ☐ / DEAD ☐ }

REMATURE OR <2500 gm. _____ | STILLBIRTHS _____

WARD

FULL NAME

YEAR OF BIRTH

HOSPITAL NUMBER

PHYSICIAN

EAR | WT. | GEST. | COMPLICATIONS | POST PARTUM

PREV C/S _____

HIGH RISK SCORE | 1ST VISIT | 30 WEEK | AND/OR ON ADMISSION

ALLERGIES – DRUGS

AMILY HX | CONGENITAL DEFORMITY | TB | DIABETES | TWINS | HYPERTENSION | BLEEDING

GENETIC HX

ED. AND SURG. | DIABETES | CORE BX | EPILEPSY | U.T.I.

RESENT HX | MEDICATION | INFECTION | INFERTILITY | SMOKING

ETHNIC GROUP

CAUCASIAN	
NATIVE	
INUIT	
OTHER	

XAMINATION | DATE | WEIGHT | B.P. | HEIGHT

HEAD AND NECK | BREASTS | PELVIC

HEART | LUNGS | CERVIX

ABDOMEN | EXTREMITIES | CORPUS

ADNEXA

OBSTETRICAL PELVIC ASSESSMENT

PREV. TRANSFUSION YES ☐ NO ☐

Hgb

S.T.S

Rh.

LAB NO

WinRho

ANTIBODIES

URINE	P	S	MICRO	C AND S
CERVIX	PAP.			C AND S

PREGNANCY TEST | DATE

A.F. PROTEIN

HEPATITIS BsAg (FOR RISK GROUP ONLY)

RUBELLA

BLOOD SUGAR 2 hr. p.c.

DATE	WT.	BP.	URINE P / S	WEEKS	FUNDUS	POSITION	FH	MED AND REMARKS	RETURN IN

PRE-NATAL SCORING FORM

PRE-NATAL RECORD

PRENATAL SCORING FORM

1) Score each question as indicated 2) Total each category score at 1st visit 3) Repeat at 36 weeks 4) Repeat on admission 5) Record on P N sheet

I. REPRODUCTIVE HISTORY

AGE
- <16 = 1
- 16 - 35 = 0
- >35 = 2

PARITY
- 0 = 1
- 1 - 4 = 0
- 5 + = 2

PAST OB HISTORY

- HABITUAL ABORTION / INFERTILITY = 1
- P P H / MANUAL REMOVAL = 1
- BABY >9 LBS (4082 gm) = 1
- BABY <5½ LBS (2500 gm) = 1
- P E T / HYPERTENSION = 1
- PREVIOUS CAESAREAN = 2
- STILLBIRTH OR NEONATAL DEATH = 3
- PROLONGED LABOUR OR DIFFICULT DELIVERY = 1

II. ASSOCIATED CONDITIONS

- PREVIOUS GYNAECOLOGICAL SURGERY = 1
- CHRONIC RENAL DISEASE = 2
- GESTATIONAL DIABETES = 1
- DIABETES MELLITUS = 3
- CARDIAC DISEASE = 3

OTHER MEDICAL DISORDERS
(Chronic bronchitis, Lupus, Etc)
SCORE ACCORDING TO SEVERITY = (1 to 3)

III. PRESENT PREGNANCY

		1st VISIT	36 WEEKS	ON ADM
BLEEDING				
<20 WEEKS	1			
>20 WEEKS	3			
ANEMIA <10 gm %	1			
PROLONGED PREGNANCY (42 WEEKS)	1			
HYPERTENSION	2			
PREMATURE RUPTURE MEMBRANES	2			
POLYHDRAMNIOS	2			
SMALL FOR DATES	3			
MULTIPLE PREGNANCY	3			
BREECH MALPRESENTATION				
Rh ISOIMMUNIZATION	3			

CATEGORY SCORE _____ + CATEGORY SCORE _____ + CATEGORY SCORE _____

TOTAL RISK SCORE 1st VISIT = ☐ TOTAL AT 36 WEEKS = ☐ TOTAL ON ADMISSION TO HOSPITAL = ☐

(Record scores in box on prenatal sheet)

NOTE: LOW RISK = 0 - 2
HIGH RISK = 3 - 6
EXTREME RISK = 7>

COMMENTS

NOTES

DELIVERY RECORD

TYPE OF LABOUR

INDUCTION

ANAESTHESIA

DATE OF BIRTH

SPONTANEOUS

FORCEPS

THIRD STAGE

HOUR OF BIRTH

WEIGHT

L.B./S.B./N.N.D.

EPISIOTOMY

PRES. POS.

BLOOD LOSS

NURSING

BABY - SEX

COMPLICATIONS

DOCTOR'S SIGNATURE

POST PARTUM EXAMINATION

DATE

WEIGHT

LOCHIA

B.P.

MENSES

HAEMOGLOBIN

NURSING

PELVIS

PERINEUM

URINE

BREASTS

CERVIX

CORPUS

FAMILY PLANNING

Approved By:

Number: X - 50

Date:

Category: Health Records

EVIRONMENTAL/OCCUPATIONAL HEALTH AND SAFETY PROGRAM: QUARTERLY REPORTS

Community Health Representatives, with the assistance of the consulting Public Health Inspector and Medical Officer of Health are responsible for preparing quarterly reports and recommendations for submission to the Health Care Administrator and presentation to the Board of Directors. Reports will include a summary of health and safety surveillance findings and other program activities and recommendations for corrective or preventative measures.

Approved By:

Number: X-60

Date:

Category: Health Records

ALCOHOL AND DRUG ABUSE PROGRAM: QUARTERLY REPORTS

Substance Abuse Counsellors are responsible for preparing quarterly reports on program activities for submission to the Health Care Administrator. Reports will include a summary of program activities and community response, a narrative discription of program performance and recommendations for program development.

Approved By:

Number: X-70

Date:

Category: Health Records

REPORTING OF COMMUNICABLE DISEASES

Staff nurses will assist attending physicians in completion and submission of notifiable disease reporting forms in compliance with the Province of Manitoba Public Health Act. and will ensure the notification of the Medical Officer of Health. Copies of all forms will be maintained in Health Authority files.

FORM VI

BACK

Please Report Rare Diseases and cases of Typhoid, Diphtheria or Meningococcal Infections by telephone to:
Preventive Medical Services
Winnipeg 775-9761 ext. 154.

STATISTICS CANADA

Public Health Section

National Notifiable Disease Reporting

GUIDE

(Revised for the Province of Manitoba)

List of Notifiable Diseases, with International List Numbers
(Ninth Revision International Classification of Diseases)

A. COMMON DISEASES

Intestinal Infectious Diseases

- Typhoid fever (002.0)
- Paratyphoid fever (002.9)
- Salmonellosis (003)
- Shigellosis (004)
- Food Poisoning (bacterial) (005)
  - (excluding Botulism 005.1, Salmonellosis 003, Shigellosis 004)
  - Staphylococcal (005.0)
  - Clostridium Perfringens (005.4)
  - Other Clostridia (005.3)
  - Vibrio Parahaemolyticus (006.4)
  - Bacillus Cereus (005.8)
  - Unspecified (005.9)
- E. coli Enteritis (006.0)

Tuberculosis

- A Primary Tuberculosis (010)
- B Bacteriologically Confirmed
  - 1. Respiratory (011-012)
  - 2. Non-Respiratory (013-018)
- C Not Bacteriologically Confirmed
  - 1. Respiratory (011-012)
  - 2 Non-Respiratory (013-018)

Sexually Transmitted Diseases

- Gonorrhea
- Syphilis
- Chancroid
- Chlamydia
- Acquired immune deficiency syndrome (AIDS)

Diseases of Central Nervous System

- Meningitis
  - A Bacterial
    - Haemophilus (320.0)
    - Pneumococcal (320.1)
    - Other (All categories excluding Meningococcal 036 and Tuberculous 013)
  - B. Viral
    - Aseptic meningitis due to
    - Coxsackie (047.0)
    - Echo virus (047.1)
    - Other viral (047.8)
- Encephalitis
  - Western equine encephalitis (062.1)

Other Bacterial Diseases

- Brucellosis (023)
- Diphtheria Cases (032)
- Diphtheria Carriers (V02.4)
- Meningococcal infections (036)
- Pertussis (033)

Other Viral Diseases

- Hepatitis A (070.0)
- Hepatitis B (070.2)
- Measles (055)
- Mumps (072)
- Rubella (056)
- Congenital Rubella (771.0)

B. RARE DISEASES

- Amoebiasis (006)
- Anthrax (022)
- Botulism (005.1)
- Cholera (001)
- Lassa Fever (078.8)
- Leprosy (030)
- Malaria (084)
- Plague (020)
- Poliomyelitis (045)
- Psittacosis (073)
- Rabies (071)
- Smallpox (050)
- Tetanus (037)
- Trichinosis (124)
- Tularaemia (021)
- Viral Haemorrhagic fever (078) (065)
- Yellow fever (060)

C. EPIDEMIC FORMS OF OTHER DISEASES AND UNUSUAL CLINICAL MANIFESTATIONS NOT OTHERWISE REPORTED.

D. DISEASES REPORTABLE BY HOSPITALS

- Glomerulonephritis, post streptococcal (580)
- Rheumatic fever (390-398)

E. DISEASES REPORTABLE BY LABORATORIES

- Campylobacter Infections (005)
- Giardiasis (007)
- Legionnaire's Disease (482)
- Parasitic Diseases, other
- Q – fever (083)
- Relapsing Fever (087)
- Rocky Mountain Spotted Fever (082)
- Rotavirus Infection (008.6)
- Yersinia Infections (027)

En. M.R. 14/80; Am. M.R. 139/87.

SCHEDULE FORM I
(SECTION 3)

MANITOBA
DEPARTMENT OF HEALTH

REPORT OF COMMUNICABLE DISEASES
REGULATIONS UNDER THE PUBLIC HEALTH ACT
To be filled out by the Attending Physician or Hospital

PLEASE PRINT — PRESS HARD

ONSET DATE _____

City
Municipality
Town or Village _____ Postal Code

Name _____

Address _____
City, St., & No. (Sec., Tp., Rge.) House or Camp

Racial Origin _____ (Treaty Indian)
(If Treaty Indian underline)

Sex _____ Age _____

Was patient immunized against this disease? Yes No

Material Used _____ Doses _____ Year _____

Is Diagnosis Clinical? _____ Laboratory? _____

ATTENDING PHYSICIAN _____
Please print

SIGNATURE _____

AS A CASE OF (Underline)

Intestinal Infectious Diseases

- *Typhoid fever (002.0)
- Paratyphoid fever (002.9)
- Salmonella infections (003)
- Shigellosis (004)
- *Food poisoning (bacterial)
  - Staphylococcal (005.0)
  - Botulism (005.1)
  - C. perfringens (005.2)
  - B. cereus (005.8)
  - Other (specify below) (005.9)
- E. coli enteritis (008.0)

Other Bacterial Diseases

- Brucellosis (023)
- *Diphtheria cases (032)
- Diphtheria carriers (V02.4)
- *Meningococcal infections (036)
- Pertussis (033)
- Tuberculosis - specify type below
- Venereal Diseases - Use NH1 form

Diseases of Central Nervous System

Meningitis
- A. Bacterial
  - Haemophilus (320.0)
  - Pneumococcal (320.1)
  - Other (specify below)
- B. Viral
  - Aseptic meningitis due to
    - Coxsackie (047.0)
    - Echo virus (047.1)
    - Other viral (specify below) or unknown (047.9)

Encephalitis
- Western Equine Encephalitis (062.1)
- Other Viral Encephalitis (specify)

Other Viral Diseases

- Hepatitis A (070.0)
- Hepatitis B (070.2)
- Measles (055)
- Mumps (072)
- Rubella (056)
- Congenital Rubella (771.0)

OTHER DISEASES INCLUDING RARE* AND IMPORTED* (SPECIFY)

_____

ADDITIONAL INFORMATION _____

Fill out separate card for each case. For epidemics of other diseases use surveillance report.
Telephone report to Medical Officer of Health or Preventive Medical Services (775-9761) for diseases indicated by (*)
This copy for MEDICAL OFFICER OF HEALTH

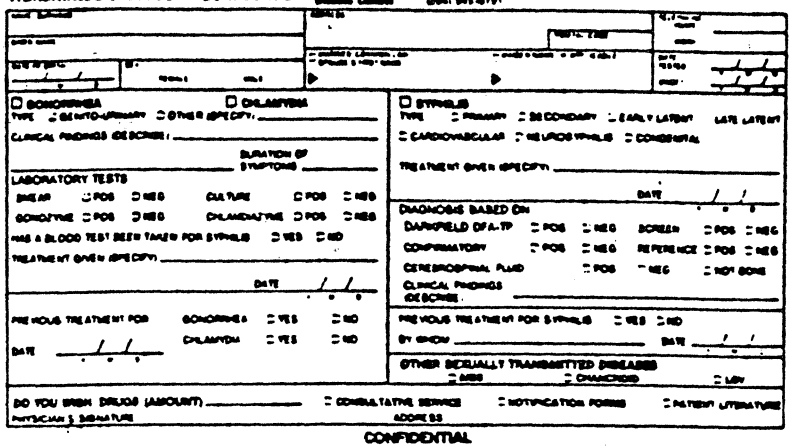
MG-4197 (Rev. 79)

Ed. M.R. 14/80.

SEPTEMBER, 1982

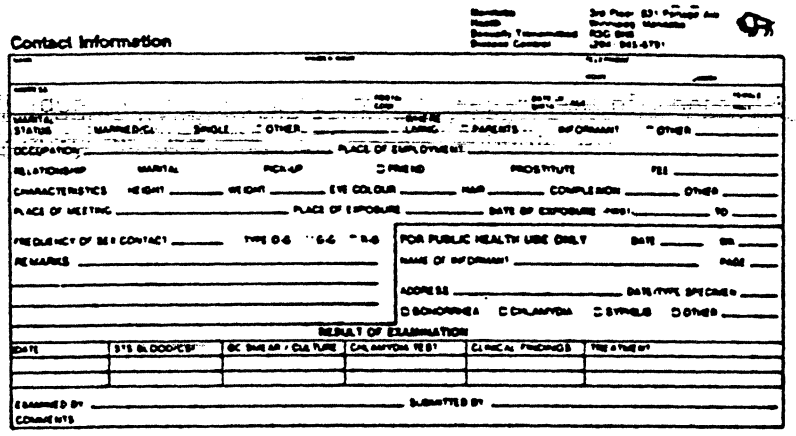
FORM I

Notification of Sexually Transmitted Disease – Confidential



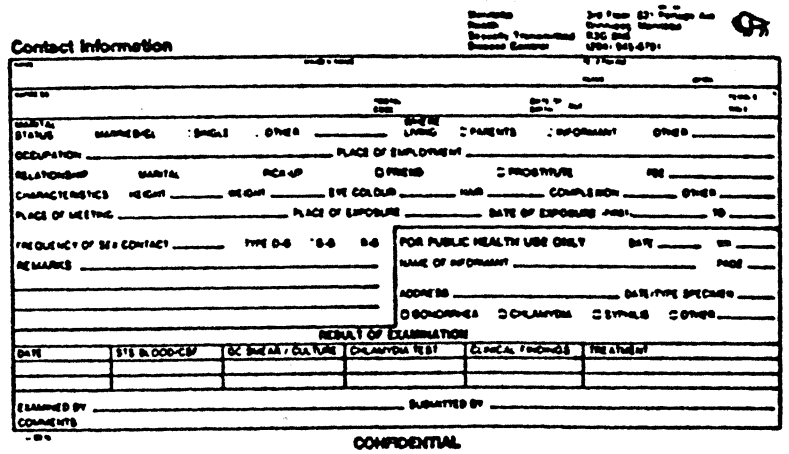
CONFIDENTIAL

Contact Information



CONFIDENTIAL

Contact Information



CONFIDENTIAL

En. M.R. 139/87.

Approved By:

Number: Y-80

Date:

Category: Health Records

IMMUNIZATION STATUS REPORT

Immunization Status Reports will be completed annually by staff nurses. Once copy will be maintained in Health Authority Files. One copy will be forwarded to the Medical Officer of Health.

The aim of an Immunization Program Status Report is to find out the level of immunity within a community. It is not just a count of immunization given, but of those persons who are expected to be immune through immunization or actual disease. If a person has had a DOCUMENTED case (laboratory proven) count them as immunized, other than Diptheria and Tetanus.

Explanation of the Form

The count should determine the immunization status of the client population as of the end of the day on the 31st of December of each year. The count should be done on all individuals living in the community regardless of where they get their immunizations completed, e.g. physician's office, off reserve schools, etc.

Age groups should be broken down as follows:

Infants - under 1 year of age

Pre-school - 1 year to 4 years of age inclusive

School-age - 5 years to 19 years inclusive. Individuals who ar 16 years to 19 years who do not attend schools should be counted as adults.

Adults - 20 years of age and older plus those individuals 16 to 19 year not attending school.

The comment section should be completed to explain the level of coverage. How many individuals refused immunization and for what reaseons, e.g. religious beliefs? Was there an epidemic that affected/delayed immunization? Did you delay immunizations because of gamaglobulin being given? Were there infrequent clinics? Do school children go to off reserve schools? These comments will help to explain fluctuations of levels of immunity.

Factors to Consider in Completing the Status Report

Firstly, you must be conversant with the immunization schedules. Note that the immunization schedule is different for individuals that begin their immunization under 7 years of age and for those individuals who begin immunization after 7 years of age. Immunization series should not be repeated no matter what length of time between injections.

1. Infants
   a) DPT and Polio - the child is considered up to date if they are under 2 months of age or if they are two months of age and over and are on schedule (not due for any immunization). If they are behind in their schedule by one then they are up to date less one. If they are behind in their schedule by 2 injections they are not counted as immunized but are counted in the population figures.

   b) Measles - If the infant is under six months of age count measles as being complete because there may be passive protection from birth. If the infant is six months of age or older measles should have been given to be considered to be complete.

   c) Tuberculosis (BCG) - If the infant received a successful BCG they are considered complete. They are eligible for BCG at 3 days of age. Once given they are considered complete for life.

2. Pre-School
   a) DPT and Polio - A pre-schoolder is considered up to date if they have completed their primary series of 3 injections and are not due for their booster. If they are missing one injection in their primary series or are due for their booster they are considered up to date less one. Once they receive this injection they are complete until the next booster is due.

   b) Measles/Mumps/Rubella - These are counted separate even though the pre-schoolder may have received them together as "MMR". As the measles given under 1 year of age provides limited protection it should not be counted as providing protection after 1 year of age.

   c) Tuberculosis (BCG) - Successful BCG given at any age is considered complete for life.

3. School Age
   a) DPT and Polio - The same applies as for pre-schoolers. DPT is given up to the end of the 6th year of age and the Td is given. Pertussis is not counted for this age group. A primary series for achild beginning immunization 7 years of age or older has only two injection of Td; therefore, once they receive two Td's they are completed until their booster is due.

b) Measles/Mumps/Rubella - Considered complete if they received any of these injections after 1 year of age.

c) Tuberculosis (BCG) - Successful BCG given at any age is considered complete. A school child who has received a second BCG, successful or not due to a negative mantoux or no history of a take, is also considered complete.

4. Adults
Adults should have a booster of Td every 10 years. Boostering of Polio is no longer required.

IMMUNIZATION PROGRAM STATUS REPORT Period of 1 year ending _____

REGION _____ ZONE _____ COMMUNITY _____

CATEGORIES	IMMUNIZATION STATUS		NUMBER		
			INDIAN	INUIT	OTHER**
INFANTS	diptheria	up to date			
Age under 1 year	pertussis	up to date less one			
population served*	tetanus				
Indian _____	polio	up to date			
Inuit _____		up to date less one			
Other _____	measles (Rubeola)				
	tuberculosis (BCG)				
PRESCHOOL	diptheria	up to date			
Age Range	pertussis	up to date less one			
1 to 4 years	tetanus				
population served*	polio	up to date			
		up to date less one			
Indian _____	measles (Rubeola)				
Inuit _____	mumps				
Other** _____	rubella				
	tuberculosis (BCG)				
SCHOOL AGE	diptheria	up to date			
Age Range	tetanus	up to date less one			
5 to 19 years	polio	up to date			
population served*		up to date less one			
Indian _____	tuberculosis (BCG)				
Inuit _____	measles (Rubeola)				
Other** _____	mumps				
	rubella				
ADULTS Age 20+	diptheria	up to date			
population served*		up to date less one			
	tetanus	up to date			
Indian _____		up to date less one			
Inuit _____	polio	up to date			
Other* _____		up to date less one			
COMMENTS:					

*Population Served: Includes all Registered Indians and others living on reserve, on Crown Land or in communities served

**Other population: Non-status Indian, Metis, and white population living on reserves or in communities served

SIGNATURE: _____ _____

Approved By:

Number X-90

Date:

Category: Health Records

BIRTH AND DEATH REGISTER

Staff nurses are to complete Province of Manitoba Vital Statistics Registration Forms for all births in the community (at home, inthe nursing station or in a camp) and all deaths in the community occurring from natural causes or known illnesses. Completed forms will be submitted to the Province of Manitoba Vital Statistics Office in Winnipeg.

The staff clerk will complete Birth and Death Monthly Report forms for all births to community residents or deaths of community residents. These forms will be maintained in the Health Authority files.

BIRTH & DEATH MONTHLY REPORT

COMMUNITY SERVED _____ MONTH ENDING _____ 198_

BIRTHS: *Please use one code: N/S: Nursing Station, H: Hospital, O: Other

NAME OF NEWBORN	MISC NO.	TREATY NUMBER	BAND OR BAND NAME	D/M/YR	PLACE	BIRTH WEIGHT	PARENT'S NAMES

DEATHS

NAME	MISC NO.	TREATY NO	BAND OR BAND NAME	D/M/Y	PLACE	BIRTH DATE YR/MO/DAY	CAUSE OF DEATH	ALCOHOL	NEXT OF KIN

NOTE: Please specify if information is not available.

Date: _____ Signature: _____

Approved By:

Number: X-103

Date:

Category: Health Records

DEATH CERTIFICATES AND BURIAL PERMITS

The following guidelines outline the reporting and certification of deaths occurring in the community:

1) All violent and/or accidental deaths occurring in the community must be immediately reported to the R.C.M.P. by the nurse. The R.C.M.P. and coroner will decide on the need for an autopsy. On the order of the coroner, the R.C.M.P. will initiate transportation for an autopsy or the release of the body to the family for burial. The registration of death form and death certificate will be completed by the coroner or the institution receiving the body for autopsy.

2) All deaths from natural causes or known illness must be reported to the Health Authority's consulting physician or patient's physician by the nurse. The R.C.M.P. does not need to be notified. If the decision is that no autopsy is required, and the physician gives his authorization, the nurse can sign the certificate with a notation to this effect. The nurse then issues the burial permit and forwards the appropriate pages to Vital Statistics.

3) All bodies cleared for burial should be held in an appropriate place in the community, such as a church or community hall, but not in the nursing station. Bodies awaiting transport for autopsy should be confined to a safe, secure location outside of the active treatment area.

Approved By: Number: X-10

Date: Category: Health Records

GENERAL GUIDELINES

Objectives of Record Keeping

1. To provide documentation of the standard of care delivered to the patient, family or community.

2. To provide a historical tool for research, assess, planning, implementing and evaluating health programs.

3. To provide information for health professionals to plan and implement care based on the needs of the patient, family or community.

Principles of Record Keeping

Records are a legal document that may be used to defend those that use them. To maintain proper standards in patient records the following principles of good record keeping will be utilized.

1. Accuracy - The record must be correct in all respects. It must convey exactly the information which it is intended to convery. The recording of opinions or suspicions should clearly be stated as such and not leave the impression of being facts.

2. Conciseness - The reocrd should be as short as possible so that no time will be wasted in reading the information nor in attempting to understnd it.

3. Legibility - The recorder should not assume the reader will be familiar with his handwriting.

4. Contemporeneity - Record immediately. All entries on the record should be made at the time the occurence being recorded took place, or immediately thereafter.

5. Individual Recording - The recording of the information should be done by the individual who saw or did the action being recorded.

6. Chronological Order - The information should be recorded in chronological order. If for some reason an entry is made out of chronological sequency, a notation should be made to this effect.

7. Identifiability - All entries on the record should be signed.

8. Uniformity and Omissions - The system of recording information should be uniform throughout the institution. No individual should, on his own initiative, omit or

add certain items not in accordance with general institutional practice. The interaction between nurses and physicians and between any staff members should be recorded in nurses's notes. Where a physician's order appears in the patient's chart, the note should indicate what was done as a result of that order. If the nurse has questioned the order, a note should be made of this fact, and of the reply that was received and the action taken. Similarly, telephone calls to physicians and others should be recorded, as well as the response to those calls.

9. Terminology and Abbreviation - The terminology used in reports should be uniform. This should also apply to any abbreviations which are used. No department or person should use abbreviation which are unknown or likely to be misinterpreted by other persons or departments to which the patient or the records may be transferred (see acceptable abbreviations attached).

10. Corrections - Make corrections openly and honestly. Any corrections should be limited to corrections of errors that have been made in the recording. In the case of an opinion which was recorded and later revised, the original opinion should remain on the record with a notation that a further opinion has been given.

11. Ink - All entries in the record will be made in ink or typewritten. Do not use pens that have erasable ink. A change in ink colour may give rise to the accusation that part of the entry was added at a later date in contemplation of a lawsuit and therefore is not accurate.

12. All care providers should be charting.

Method of Charting

All charting will use a narrative format based on the nursing process - history, assessment, diagnostic impressions, nursing plan.

1. History

   a) Reason for presentation of client.

   b) History of present illness.

   c) Drug allergies.

2. Assessment

   a) Observations

   b) Physical examination and findings

3. Impressions

   This will include all possible pathological processes occuring. List in priority fashion—most significant impressions first.

4. Plan This includes:

a) Diagnostic Plan - The procedures to prove or disprove impressions. It may include: lab tests (those sent - those done immediately with their results), x-rays or medical consultation received.

b) Thereapeutic Plan - Drug therapy and treatment recommendations as well as treatment carried out. Indicate planned return to clinic or home visit. Indicate action recommended if drugs or treatment do not work (alternative plans). Indicate how disposed of (admitted/medivaced, discharged home, referral actions if any).

ACCEPTABLE ABBREVIATIONS

Studies of Nursing Records and Reports have shown that Abbreviations, used at random, and particularly when over used, cause much difficulty in comprehension. The following abbreviations are the only ones acceptable for use.

A	abd	Abdomen
	a.c.	Before Meals
	Ad lib	Freely
	a.m.	Morning
	A/W	Alive and Well
	amt.	Amount
	ant	Anterior
	approx.	Approximately
	appt.	Appointment
	ausc	Auscultation
B	BCP	Birth Control Pill
	b.i.d.	Twice Daily
	b.m.	Bowel Movement
	B.P.	Blood Pressure
C	C.	Celcius
	c̄	With
	c.c.	Cubic Centimetre
	Ca	Cancer
	Caps	Capsules
	CARS	Canadian Arthritis & Rheumatism Society
	C&S	Culture & Sensitivity
	C.D.H.	Congenital Dislocated Hip
	CHC	Child Health Conference
	CHF	Congestive Heart Failure
	CHN	Community Health Nurse
	CHR	Community Health Representative
	cl	clinic
	cm	Centimetre
	CNS	Central Nervous System
	c/o	Complaining of
	COLD	Chronic Obstructive Lung Disease
	C.P.R.	Cardio Pulmonary Resuscitation
	CSF	Cerebral Spinal Fluid
	CVA	Cerebral Vascular Accident
D	D&C	Dilatation & Curettage
	DOA	Dead on Arrival
	D.O.B.	Date of Birth
	Dr.	Doctor
	drsg	Dressing
	D/W	Dextrose & Water
	Dx	Diagnosis
E	ECG or EKG	Electrocardiogram
	EEG	Electroencephalogram
	e.g.	For Example
	EDC	Expected date of Confinement
	EENT	Eye Ear Nose & Throat
	ENT	Ear Nose & Throat
	exam	Examination
F	F.A.S.	Fetal Alcohol Syndrome
	fe	Iron
	flu	Influenza
	font	Fontanelle
G	G.	Gravida
	Gest	Gestation
	G.C.	Conorrhea
	G.I.	Gastrointestinal
	gm	Gram
	gtt(s)	Drop(s)
	G.U.	Genital Urinary
	GYN	Gynecological
H	Hgb	Hemoglobin
	Hosp	Hospital
	hr.	Hour
	h.s.	At Bedtime/At Night
	ht.	height
	h.v.	Home Visit
	Hx.	History
	H_2O	Water
	H_2O_2	Hydrogen Peroxide
	Hz	Hertz Cycles/Second

S	s	Without
	Sch	School
	S.I.	Systems International
	sibs	Siblings
	SIDS	Sudden Infant Death Syndrome
	S.O.B.	Short of Breath
	sol'n	Solution
	ss	Half
	Staph	Staphlococcal
	Stat	Immediately
	S.T.D.	Sexually Transmitted Disease
	Strep	Streptococcal
	susp	Suspension
T	T.A.	Therapeutic Abortion
	T&A	Tonsils & Adenoids
	Tabs	tablets
	T.B.	Tuberculosis
	temp	Temperature
	T.I.D.	Three Times Daily
	tinct	Tincture
	T.L.	Tubal Ligation
	T.P.R.	Temperature Pulse & Respirations
	tx	Treatment
U	Umb.	Umbilicus
	Ung.	Ointment
	U.R.I.	Upper Respiratory Infection
	U.T.I.	Urinary Tract Infection
V	vacc.	Vaccination
	vag.	Vaginal
	V.D.	Venereal Disease
	vits	Vitamins
	v/s	Vital Signs
W	W.B.C.	White Blood Count
	wk	Week
	wt	Weight
	w/o	Without
Y	yr	Year

DATES

Use: Year/Month/Day
eg: 84.Feb.6 (Write Month)

TIME

Use: 24 Hour Clock

Biologicals and Test Abbreviations

D T	Adsorbed Diphtheria, Tetanus
DPT	Adsorbed Diphtheria, Pertussis, Tetanus
Td	Adsorbed Tetanus, Diphtheria
OPV	Oral poliomyelitis vaccine (Sabin)
IPV	Inactivated Poliomyelitis Vaccine (Salk)
QUAD	Diphtheria, Pertussis, Tetanus, Polio (Salk)
MMR	Measles, Mump, Rubella
BCG	Bacillus Calmette-Guérin vaccine
MANTOUX	Tuberculin Skin Test
IG	Immune Globulin

Approved By:

Date:

Number: X1-10

Category: Drugs and Medical Supplies

ORDERING AND HANDLING

Drugs and medical supplies will be ordered and handled in accordance with Medical Services Branch Drug Formulary and Medical Supplies Index and procedures and Manitoba Regional Guildeline number 2-10 (attached).

REGIONAL GUIDELINES

MANITOBA REGION
MEDICAL SERVICES BRANCH
NATIONAL HEALTH AND WELFARE

INITIATOR:
RESPONSIBILITY: OPERATIONS
SIGNATURE:
APPROVAL:

SECTION: 2
GUIDELINE: 10
ORIG. DATE: May 1978
LAST REV. DATE: 860401

2-10 NARCOTICS AND CONTROLLED DRUG PROCEDURES

The following guidelines for the proper handling of narcotics and controlled drugs are in addition to the Guidelines outlined in Section II, of the DSS Drug Distribution Program Manual.

1. Narcotics or controlled drugs should arrive in the unit accompanied by an issue voucher. The drugs should be counted and if the counted number is the same as the number issued, the voucher should be signed and returned to Zone. If count is incorrect, the drugs should be returned to the point of origin.

2. The Narcotics Act covers narcotics and the Food and Drug Act covers controlled drugs. Under the updates of these Acts, the drugs have been divided into two groups and the rules covering these groups apply to both narcotics and controlled drugs. Group A should be locked up and accounted for dose-by-dose (see point 4). Group B need to be locked up but NOT counted. The lists of these medicines are attached as Appendix A.

3. The newly received drug supply is either added to the existing count, e.g.:

Previous Balance			2	K. Johnston
September 2/79	25	Received	27	K. Johnston

or a new sheet is started. Count sheets can be order from Zone.

The narcotics book should also contain a section for controlled drugs.

All narcotics and controlled drugs, regardless of which group, should be recorded initially in the book. e.g. 222.

September 2/79	1,000	Received	1,000	K. Johnston

4. For drugs in Group A only: The name of each patient who received medication must be on the count sheet with date, time, dosage, amount left in supply and signature of administering nurse and name of attending physician.

5. A count of drugs in Group A must be done at a minimum of once a month by the Nurse-in-Charge and another nurse.

   Additional counts must be done:

   a) before a nurse leaves the station for more than five working days.

   b) when the Zone Nursing Officer or Regional Nursing Officer visits the station. The count will be done in the presence of an incumbent nurse. The count, date of count, and notation "counted and checked" will be recorded on the count sheet, and the count sheet signed by both Nursing Officer and Nurse.

   c) as directed by the Zone Nursing Officer, e.g., large, busy or chronically short counted stations.

6. If a shortage of Group A drugs is discovered after a drug count, contact your Zone Nursing Officer immediately, and follow up with an incident report detailing the discrepancy and investigation. The Zone Nursing Officer must inform the Zone Director, who will contact the Regional Supervisor of the Bureau of Dangerous Drugs (telephone 949-3747 Winnipeg), and appropriate action will be taken. For all instances of theft and significant loss the use of the HPB 3131 Loss or Theft Report should be completed. A sample of this form is attached as Appendix B.

7. Unserviceable injectable narcotic or controlled drugs, in quantities that represent a partial dose from an ampoule, must be destroyed by an employee who is a health professional. A health professional is defined as the person in charge of a hospital or Nursing Station, a pharmacist, nurse, pharmacy intern or an inspector from a provinical pharmacy licencing authority (where applicable). It may be done on the spot, with or without a witness, and a notation entered on the appropriate records.

   In a hospital setting, Narcotics and Controlled Drugs, other than injectables referred to above, must be returned to the hospital pharmacy for destruction in accordance with procedures described for the main drug supply.

8. When a Nurse-in-Charge at a field unit identifies a need to dispose of narcotics and controlled drugs, a detailed list must be forwarded to the Zone Director identifying the name of the drug, the quantity and the reason for disposal. Use Destruction Form HPB 3414 (8-73), copy attached as Appendix C. These forms can be ordered from Zone.

   The Zone Director will review the request for disposal and request disposal instructions from the Regional Manager of the Bureau of Dangerous Drugs.

   Regional Manager
   Health and Welfare Canada
   Health Protection Branch
   Bureau of Dangerous Drugs
   301-269 Main Street
   Winnipeg, Manitoba
   R3C 1B2 (949-3747)

   The Regional Manager will assess the request and decide whether a Bureau presence is needed at the destruction.

If a Bureau presence is not needed, the Regional Manager will write authorizing the destruction. This authorization must be retained on file in the facility's Narcotic and Controlled Drug records covering the main supply. The authorization, which expires sixty (60) days from date of issue, will indicate that permission for destruction is valid for one occasion only, and covers only the drugs listed on the request.

The pharmacist or NIC, or the health facility pharmacy or main drug room, will destroy the drugs in the presence of a health professional.

After destruction, a list of the destroyed drugs will be dated and signed by the two officals who took part in the destruction and the list filed with the Narcotic and Controlled Drug records covering the main supply. It will not be necessary to send copies to the Bureau's Regional Office.

If a Bureau presence is needed at the destruction, the inspector who participates will retain a list of the drugs destroyed. At the same time, a copy must be filed with the hospital's Narcotic and Controlled Drug records.

9. Narcotic keys must ALWAYS be in the possession of one of the nurses. The Nurse on Call must maintain possession of the keys during the call period. The keys must not be left in a desk drawer, hanging from a door knob, or left in the pocket of a lab coat that is hanging anywhere in the facility.

GROUP A - LOCKED AND REPORTED ON

NARCOTICS

Codeine Phosphate
Cophylac
Demerol
Lomotil
Morphine
Pethidine HCI (Demerol)
Talwin
Dextropropoxyphene
Atasol 30
Camphorated Opium
Ticture B.P.
Exdol 15,30
Robaxisal C 1/4, 1/8
Tylenol with Codeine (#2, #3)
282
292

CONTROLLED DRUGS

Secobarbital Sodium
Seconal Sodium
Pentobarbital Sodium
Phelantin

GROUP B - LOCKED BUT NOT REPORTED ON

NARCOTICS

Donnagel PG
Paregoric
Parepectolin
Atasol 8
Exdol 8
Painex 1/8
Tylenol with Codeine #1
222

CONTROLLED DRUGS

Phenobarbital
Luminal
Chemo - 60 - 120
Bellandenal
Brochomspasm
Cafergot PB
Chemfedral
Chemspast
Dilancabarb
Donnatal
Pro-Banthine with Phenobarbital
Prostalgine
Robaxisal - PH
Tedral - All forms

APPENDIX B

Health and Welfare Canada / Santé et Bien-être social Canada
Health Protection Branch / Direction générale de la protection de la santé
Bureau of / Bureau des
Dangerous Drugs / drogues dangereuses

NARCOTIC/CONTROLLED DRUG LOSS/THEFT REPORT
RAPPORT DE PERTES OU DE VOLS DE STUPÉFIANTS ET/OU DE DROGUES CONTRÔLÉES

DATE OF OCCURRENCE / DATE DE L'INCIDENT — DAY – JOUR / MONTH – MOIS / YEAR – ANNÉE

NAME – NOM

STREET – RUE | CITY – VILLE | PROVINCE

POSTAL CODE – CODE POSTAL | TELEPHONE – TÉLÉPHONE

BUREAU USE ONLY / À L'USAGE DU BUREAU SEULEMENT
FILE NO – DOSSIER

REGIONAL OFFICE / BUREAU RÉGIONAL

☐ PHARMACY / PHARMACIE (PHARMACIES)
☐ HOSPITAL / HÔPITAL
☐ PRACTITIONER / PRATICIEN
☐ DEALER / DISTRIBUTEUR
☐ OTHER (SPECIFY) / AUTRES (PRÉCISER) _____

TYPE OF LOSS (Check (✓) appropriate box) — TYPE DE PERTE (cocher (✓) la case appropriée)

☐ BREAK AND ENTER / VOL PAR EFFRACTION
☐ ARMED ROBBERY / VOL À MAIN ARMÉE
☐ BURGLARY / CAMBRIOLAGE
☐ OTHER (SPECIFY) / AUTRES (PRÉCISER) _____
☐ SMASH THEFT / VOL À LA DEVANTURE
☐ UNEXPLAINED / PERTE INEXPLICABLE
☐ LOSS IN TRANSIT / PERTE EN COURS DE ROUTE

WAS THIS BEEN REPORTED TO THE POLICE? / CETTE PERTE A-T-ELLE ÉTÉ SIGNALÉE À LA POLICE? ☐ YES / OUI ☐ NO / NON

DETAILS:

FOR BREAK AND ENTRY — LORS D'UN VOL PAR EFFRACTION

POINT OF ENTRY / POINT D'ENTRÉE

TYPE OF ALARM / TYPE D'ALARME ☐ CENTRAL / CENTRALE ☐ LOCAL / LOCALE ☐ NONE / AUCUNE

TYPE OF SAFE / SECURITY CABINET / GENRE DE COFFRE-FORT OU DE CABINET DE SÉCURITÉ

WERE DRUGS TAKEN FROM SAFE/SECURITY CABINET? / LES DROGUES ONT-ELLES ÉTÉ PRISES DU COFFRE-FORT OU DU CABINET DE SÉCURITÉ? ☐ YES / OUI ☐ NO / NON

ARE ADDITIONAL SECURITY MEASURES BEING TAKEN TO PREVENT FURTHER LOSSES? / IF SO PLEASE BRIEFLY DESCRIBE / MESURES DE SÉCURITÉ ADDITIONNELLES SONT-ELLES PRISES POUR PRÉVENIR D'AUTRES PERTES? SI OUI DÉCRIVEZ-LES BRIÈVEMENT

HEADQUARTERS / ADMINISTRATION CENTRALE

FOR LOSS IN TRANSIT — LORS D'UNE PERTE EN COURS DE ROUTE

NAME OF TRANSPORT COMPANY – NOM DE LA COMPAGNIE DE TRANSPORT

LIST OF DRUGS LOST OR STOLEN (Use a separate page if necessary) / LISTE DES DROGUES PERDUES OU VOLÉES (Annexez une autre page, au besoin)

QUANTITY / QUANTITÉ	DRUG / DROGUE	QUANTITY / QUANTITÉ	DRUG / DROGUE

ATTACHMENT / PIÈCE JOINTE ☐ YES / OUI ☐ NO / NON

SIGNATURE	NAME AND TITLE OF OFFICIAL / NOM ET TITRE DU RESPONSABLE	DATE

HPB 3-3-2 84

- Please submit to Regional Office within ten days of discovery of loss. (White and pink copies only)
- À soumettre au Bureau régional dans les dix jours qui suivent la constatation de la perte. (Copies blanche et rose seulement)
- Regional Offices addresses on reverse.
- Adresses des bureaux régionaux au verso.

WHITE AND CANARY — REGIONAL OFFICE-BDD
BLANCHE ET JAUNE — BUREAU RÉGIONAL-BDD

PINK — PROVINCIAL PHARMACY AUTHORITY (if required)
ROSE — AUTORITÉ PHARMACIE PROVINCIALE (si requis)

GOLD — PHARM/
OR — PHARM

Health and Welfare Canada
Health Protection Branch

DESTRUCTION FORM

NAME (Pharmacy-hospital, licensed dealer, estate, etc.)

ADDRESS DATE

TO WHOM IT MAY CONCERN

The following Narcotic and/or Controlled Drug (Schedule G) material having become unserviceable, was destroyed _____
at the request of _____
and
in the presence of _____
and
witnessed by the undersigned Inspector

Item - Article	Item - Article

Signature of Official

Signature of Inspector

To be prepared in duplicate
Original to be retained by the Account
Copy to be forwarded to the Department

Approved By:

Number: XII-10

Date:

Category: Laboratory Procedures

MEDICAL SERVICES BRANCH LABORATORY MANUAL

Medical Service Branch Manitoba Region Laboratory Manual for Nursing Stations provides procedural guidelines for nursing staff in collecting speciments and performing basic laboratory.

Approved By:

Number: XIII - 10

Date:

Category: Emergency Procedures

COMMUNITY EMERGENCY RESPONSE PLAN

The Health Care Administrator is responsible for ensuring that all staff are familiar with the Emergency Response Plan and their respective roles in emergency situations.

EMERGENCY PROTOCOLS XIII - 20

MEDICAL SERVICES BRANCH in press

AERO MEDEVAC GUIDELINES XIII -30

MEDICAL SERVICE BRANCH in press

Approved By:

Date:

Number: XIV - 10

Category: X - Rays

X - RAYS IN NURSING STATIONS

1. At all times careful consideration must be given whether it is essential to take an x-ray at a nursing station.

2. The taking of x-rays is restricted to the following:

   °only nursing staff who have received orientation from a qualified x-ray technical person. visiting x-ray radiographers or visiting physicians may take x-rays.

   °chest x-rays for surverys or diagnostic purposes. Children under 4 years of age should not have a chest x-ray for a survey as they are difficult to hold and the resulting x-ray films are of poor quality.

   °x-rays of extremities to exclude bony or tissue injuries, e.g., dislocations or fractures: A lateral as well as antero-posterior (AP) view should be obtained. If there is some doubt as to whether or not a limb is fractured, and if there is no physician present to read the x-ray, the patient shall be evacuated for assessment by a radiologist. A back slab cast should be used to support the limb. Full casts can only be applied by a physician

   °x-rays of the pelvis (not the abdomen) on the order of the physician, when there is concern that an Intrauterine Contraceptive Device (IUD) may have been lost.

   °in life threatening situations, on the order of and in the presence of a physician, x-rays of skulls, abdomens and hips may be taken provided that:

   *the physician is willing to prepare a report and

   *the physician is informed that our radiological consultants state that "the films from our x-ray units are not of diagnostic quality"; diagnostic film of the abdomen or hip is difficult to obtain, and untrained personnel usually cannot position the skull appropriately, and

   *the correct procedure is used.

3. If a film is taken, it must be sent with the patient who is going to a hospital or to see a physician. All other x-ray film must be sent for consultation radiologist viewing. If a qualified physician reads the film on site and prepares a report for file, this will be adequate.

4. The following precautions must be taken by all x-ray operators:

   °Persons taking x-rays or in the x-ray environment must wear monitors while on duty and take full advantage of protective screens and other protective devices.

If no protective barriers are available, the operator should wear a protective lead apron with the monitor underneath at waist level.

°No person who is pregnant, or considers that she might so be, will take any part in the taking of x-rays. A notice to this effect, in English and the appropriate Indian language, shall be displayed in the vicinity of the x-ray unit.

°Generally, nursing station staff should not hold patients for x-ray. If required a friend or relative wearing protective apron and gloves should hold the patient.

°The x-ray beam should be collimated to the area of interest.

INTERPRETATION:

1. All chest x-rays should be sent for review and interpretation to:

   Sanatorium Board of Manitoba
   2nd Floor - 629 McDermot Avenue
   Winnipeg, Manitoba
   R3A 1P6

2. All other x-ray films should be sent for review and interpretation to:

   Radiology Consultants of Winnipeg
   202 Medical Arts Building
   233 Kennedy Street
   Winnipeg, Manitoba
   R3C 3J5

   or

   Consultant Radiologist
   Thompson General Hospital
   Thompson, Manitoba

When there is a visiting physician at the Nursing Station, the physician may be able to read the film. However the film should still be sent to a radiologist for interpretation.

An x-ray examination should only be taken if a nurse or a physician deems it necessary.

RECORD OF X-RAY EXAMINATION

Nurses will maintain a record of all x-ray examinations completed. The record book should be maintained in or adjacent to the x-ray room, to ensure that recording of x-ray examinations occurs at all times.

ORDERING PROCEDURE FOR X-RAY SUPPLIES - NURSING STATIONS

Listed below are the estimated one year requirements for x-ray supplies at a Nursing Station. Each year's stock should be checked prior to placing your annual order.

1. Developer and Fixer

12 - Kodak GBX1900984 Developer-Replenisher to make 5 gal. liquid.

12 - Kodak GBX1900943 Developer-Replenisher to make 1 gal. liquid.

12 - Kodak GBX1902485 Fix to make 5 gal. liquid.

These chemicals should be ordered in time to go in by winter road where possible, as x-ray chemicals should not be sent by aircraft due to D.O.T. Regulations. Special packaging is required for air shipments.

2. X-Ray Film

Film should be ordered only as required, as the film becomes outdated. Outdated film becomes fogged and unusable.

1 Box of 50 Sheets 10 x 12 Dupont Cronex 4 L Film

1 Box of 50 Sheets 14 x 17 Dupont Cronex 4 L Film

Any film boxes not in use in the film bin should be sorted in a dry cool place away from the x-ray department.

When a new box of film is placed in use in the film bin, the cover should be kekpt on the film box. This will provide extra protection against ligh fog in case an unfamiliar person should open the film bin with the lights on.

Approved By:

Date:

Number XIV-20

Category: X-Rays

RADIATION PROTECTION MONITORING

The Radiation Protection Bureau, Health and Welfare Canada, is responsible for monitory the x-ray unit to ensure that radiation emitted by the x-ray equipment is within acceptable limits. The Health Protection Branch operates a TLD (Thermoluminescent Dosimetry) service through the use of radiation badges or monitors.

A monitor is assigned to an individual and therefore only the person who has been assigned the monitor should wear it. The Health Care Administrator will assign one staff nurse the responsibility of assigning and controlling the monitors. Monitors must be owrn by staff at all times while on duty. Monitors must not be left in the x-ray room as erroneous radiation levels will result.

All of the monitors are to be mailed to the Radiation Protection Bureau on a quarterly basis for assessment, and the Bureau in turn completes an assessment report on the radiation levels. Prior to the required mailing date, the Bureau automatically mails another set of monitors to the Nursing Station, and a supply of monitors is therefore availabe at all times.

The Bureau has agreed to provide 4 spare monitors for the Nursing Station which may be used by a new employee, relief employee, etc. The 4 spares should be an adequate supply until the next set of monitors arrive. However, if additional monitors are necessary, a telephone call may be placed to the Radiation Protection Bureau (RPB), as detailed below:

Health and Welfare Canada
Radiation Protection Bureau
Brookfield Road
Ottawa, Ontario
K1A 1C1

Telephone No.: (613) 998-3777

Contract Person: Ms. Norma Turnbull
Mr. Rone Cole

If an interpretation of the technical aspects of the reports is reuqired the Technical Section or the RPB may be contacted at:

Telephone No.: (613) 998-4797

If it becomes necessary to contact the Bureau in writing or by telephone, the Group number of Identification Number assigned to the Nursing Station must be stated.

WEARING MONITORS:

1. Monitors shall be stored in the monitor storage rack, which is located outside of the x-ray room, and marked with the employee's name.

2. The monitor assigned to the employee must be worn by the employee while on duty and when operating the x-ray equipment or assisting in koperating the equipment (this includes surveys).

3. When going off duty the monitors must be returned to the storage location outside of the x-ray room, in the monitor storage rack.

4. Each monitor should only be used by the person to whom it has been assigned.

ISSUE OF MONITORS:

1. The Radiation Protection Bureau (H&WC) mails a Name List (pink form) quarterly to the Nursing Stations together with a supply of monitors.

2. On receipt of the list, it is verified by the clerk to ensure staff names, S.I.N. and monitors are correctly assigned.

3. When a new nurse arrives, the employee shall be assigned a "spare monitor". The name period, monitor number and social insurance number (S.I.N.) shall be recorded on the list. Under the Comments Section, record "new employee assigned spare monitor - replacement spare required".

4. At the end of the period, mail the name list and all monitors to the Radiation Protection Bureau.

5. The mailing carton and pink sheet should be stored in the monitor rack.

RELIEF NURSES:

Relief nurses will use the spare monitors at the respective Nursing Stations. The normal data is recorded on the name list. Also note on the form, "relief nurse only: do not assign permanent monitor". Each monitor should only be used by the person it is assigned to.

EMPLOYEE TERMINATION:

When an employee terminates, record in comments "employee terminates" and include the date. Return the monitor to RPB at the end of the quarter.

Approved By:

Date:

Number: XIV-30

Category: X-Rays

SAFETY INSPECTION AND MAINTENANCE OF EQUIPMENT

The Radiation Protection Bureau of Health and Welfare Canada will conduct bi-annual inspections of x-ray equipment and submit reports and recommendations to the Health Care Administrator, Medical Services Branch and the Federal Government's x-ray maintenance consultant. The Health Care Administrator is responsible for arranging for and ensuring proper action by Medical Service Branch and their consultant.

Approved By:

Date:

Number: XV-10

Category: Facilities and Equipment

REPLACEMENT

Health and Welfare Canada is responsible for timely replacement, upgrading, expansion or adddition to facilities and equipment inventories in accordance with the joint pre-transfer facilities and equipment assessment and replacement plan.

Approved By:

Number: XV-20

Date:

Category: Facilities and Equipment

AUTHORIZED USE

Health Authority facilities and equipment are for the use of Health Authority employees and contract personnel in the performance of their assigned duties and for the accommodation of staff and visiting health care personnel. Use for any other purpose requires prior approval from the Health Care Administrator.

Approved By:

Number: XVI - 10

Date:

Category: Finance

FINANCIAL PROCEDURE

Health Authority finances shall be handled in accordance with the Swampy Cree Tribal Council Financial Procedure Manual For Individual and Regional Health Units.

SWAMPY CREE TRIBAL COUNCIL

FINANCIAL PROCEDURE MANUAL FOR INDIVIDUAL AND REGIONAL HEALTH UNITS

MARCH 27, 1989

SWAMPY CREE TRIBAL COUNCIL

FINANCIAL PROCEDURE MANUAL FOR INDIVIDUAL AND REGIONAL HEALTH UNITS

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SWAMPY CREE TRIBAL COUNCIL

FINANCIAL PROCEDURE MANUAL FOR INDIVIDUAL AND REGIONAL HEALTH UNITS

OBJECTIVE

The purpose of the Financial Procedure Manual is to document:

- key internal controls to safeguard health unit funds and assets; and
- key financial accounting systems and procedures.

The internal controls, systems and procedures for the individual and regional health units are based upon:

- the incumbent possessing basic accounting skills;
- most health units having limited numbers of accounting/administrative staff (i.e., one administrator and one clerk) to perform all accounting functions including the preparation of monthly financial statements; and
- manual accounting systems due to funding constraints for computer hardware and software.

I. BASIC INTERNAL CONTROLS

1. GENERAL

Each health unit will have its own distinct bank accounts:

- a chequing account for operating purposes; and
- a savings account for investment of surplus funds.

These bank accounts will be separate from other band or council bank accounts.

2. CONTROLS OVER RECEIPTS

A) Cheques

i) All incoming cheques will be restrictively endorsed.

ii) All incoming cheques will be described in detail in the bank deposit book.

iii) The amount of the deposit will be recorded in the cash receipts journal.

iv) All incoming cheques will be promptly deposited in the bank account.

B) Cash Receipts

The individual health and regional units are not likely to receive very many cash receipts. Any cash receipts will be handled as follows:

i) Pre-numbered receipts will be issued for all money at the time of receipt.

ii) All duplicate copies will be accounted for.

iii) A comparison will be made between the aggregate of the receipts issued and the amount deposited in the bank.

iv) The amount of the deposit will be recorded in the cash receipts journal.

v) Cash receipts will be promptly deposited in the bank.

C) Cash Collections

i) Cash collections will be under the control of two individuals when it is not practical to issue receipts.

ii) Cash collections will be promptly deposited in the bank.

iii) The amount of the deposit will be recorded in the cash receipts journal.

3. CONTROLS OVER DISBURSEMENTS

i) Upon opening the mail, all supplier invoices will be forwarded to the administrative/accounting clerk and filed in an open invoice file by payment date.

ii) On a weekly basis, the open invoice file will be reviewed and all supplier invoices that are due will be pulled for payment.

iii) All supplier invoices for payment will be checked for clerical accuracy and receipt of goods or services.

iv) All disbursements will be made by cheque and supporting documentation (i.e., supplier invoices, etc.) will be kept for each disbursement. (Limited payments will be made by way of a petty cash fund.)

v) All cheques will be recorded in a cash disbursements journal.

vi) All cheques will require two authorized signatures.

vii) All supporting cheque documentation will be stamped "PAID" and include a reference to the cheque number.

viii) Support for all cheques will be filed by budget caption in separately titled file folders.

4. CONTROLS OVER PAYROLL RECORDS

i) All individual compensation, including any changes, will be approved by the health unit Board of Directors.

ii) A separate employee file will be kept for each employee. At a minimum, the individual employee file will contain:

- the employee application for employment;
- a letter offering employment to the employee with signed acceptance by the employee; and
- evidence of Board of Directors approval of the compensation rate and any changes.

5. CONTROLS OVER PETTY CASH

i) All petty cash payments will be supported by a petty cash voucher and expense receipts.

ii) Recipients of petty cash payments will be required to sign the petty cash voucher payment form as evidence of payment.

iii) The petty cash fund will be reimbursed by way of cheque. Regular cheque disbursement controls will apply.

iv) The Administrator will count and balance the petty cash fund on a monthly basis.

6. CONTROLS OVER EMPLOYEE ADVANCES

i) Employee advances will only be for out of town business trips.

ii) All employee advances will be approved by the Administrator, and paid by cheque. Regular cheque disbursement controls apply. (Any advances to the Administrator will be approved by the Board.)

iii) Employees will be required to file an expense report immediately upon returning from the business trip.

iv) Employees will reimburse any excess advances received over actual expenses incurred when filing their expense report.

v) Expense reports will include receipts for all incurred expenses and be signed by the employee and approved by the Administrator. (The Administrator's expense report will be approved by the Board.)

vi) A monthly reconciliation will be done to identify all outstanding advances, and the reconciliation will be approved by the Administrator.

7. CONTROLS OVER THE BANK ACCOUNTS

i) The bank accounts (i.e., the chequing and savings accounts) will be reconciled on a monthly basis and agreed to the general ledger.

ii) The Administrator will review the chequing and savings accounts reconciliations in detail on a timely basis.

8. GENERAL LEDGER CONTROLS

i) The cash receipts and disbursements journal and the payroll journal will be balanced on a monthly and timely basis.

ii) The summarized cash receipts and disbursements journal and payroll journal will be posted to the general ledger.

iii) A trial balance of the general ledger accounts will be prepared on a monthly and timely basis.

9. FINANCIAL STATEMENTS CONTROLS

i) The Administrator will prepare monthly financial statements.

ii) The monthly financial statements will include comparisons to budget and to the prior year (after the initial year).

iii) The monthly financial statements will include narrative explanation of all differences from budget and from the prior year.

iv) The monthly financial statements will be approved by the health unit Board.

v) The annual financial statements will be audited by an independent chartered accountant within a 90 day period from the health unit year end.

10. HEALTH UNIT BOARD OF DIRECTORS CONTROLS

The individual health unit and the regional health unit Board of Directors will:

i) approve the annual health unit budget;

ii) approve the monthly and annual financial statements;

iii) approve all individual compensation and any changes in individual compensation;

iv) approve all Board of Director honoraria disbursements including honoraria rates;

v) approve all contracts, including contracted services for professionals;

vi) approve all individual cheques greater than $5,000;

vii) authorize all banking arrangements; and

viii) appoint the auditor.

II. BASIC ACCOUNTING SYSTEM

The key source documents for the accounting system will be the:

- bank deposit book; and
- cheques for supplier invoices and payroll.

These source documents will be recorded using a one-write bookkeeping system. The procedures for recording transactions in the one-write system are included in the procedures section. Examples of the one-write forms are included in a separate section (Section IV - Required Forms and Supplies). The accounting clerk will record all transactions in the one-write journals and maintain up-to-date bank balances.

At month end, the one-write journals will be summarized and posted to the general ledger. The general ledger will then be balanced and financial statements, including comparisons and explanations from budgets, will be prepared.

The general ledger will contain, at a minimum, the following accounts:

Assets:
- Bank chequing account
- Bank savings account
- Accounts receivable
- Employee advances
- Inventory of supplies
- Furniture and fixtures

Liabilities:
- Accounts payable

Equity:
- Surplus/deficit

Revenue and Expenses:
- Individual accounts for each revenue and expenditure caption contained in the individual health unit budget.

III. ACCOUNTING PROCEDURES

1. RECEIPT OF CHEQUES

Daily

i) Restrictively endorse all cheques.

ii) Record all cheques in the bank deposit book, including the details of who the cheques were from, the date of the cheques and the amount of the cheques.

iii) Total the bank deposit.

iv) Record the bank deposit in the one-write cash receipts and disbursements journal.

v) Post the bank deposit to the applicable cash receipts and disbursements journal heading. (Note: The cash disbursements and receipts journal will include headings for all items included in the health unit budget as well as all balance sheet accounts.)

vi) Calculate the updated bank balance.

vii) Take the bank deposit to the bank.

2. RECEIPT OF CASH

Daily

i) Count the cash.

ii) Issue a pre-numbered cash receipt voucher.

iii) Include the cash with the bank deposit.

iv) Balance the duplicate cash receipts vouchers to the bank deposit.

v) Post the bank deposit to the one-write cash receipts and disbursements journal.

vi) Calculate the updated bank balance.

vii) Take the bank deposit to the bank.

Monthly

i) Check that all duplicate cash receipts vouchers are numerically accounted for and that the funds for which receipts have been issued have been included with the daily bank deposit.

3. ISSUING CHEQUES FOR GOODS AND SERVICES

i) After opening the mail, file all supplier invoices in the open invoice file by payment date.

ii) On a weekly basis, review the open invoice file and pull all supplier invoices that are due for payment.

iii) Check that the health unit received the goods or services that it is being invoiced for.

iv) Check the supplier invoice for clerical accuracy.

v) Prepare a cheque using the one-write system including:

- date
- pay to the order of
- cheque number
- brief description of why payment is being made
- cheque amount.

vi) Post the amount of the cheque under the applicable cash receipts and disbursements journal heading. (Note: The cash receipts and disbursements journal will include headings for all items included in the health unit budget as well as Balance Sheet accounts.)

vii) Take the cheques and the supporting documents to the Administrator for signature. The Administrator will:

- review and approve all supporting documentation;
- stamp the supporting documentation "PAID" and include a reference to the cheque number; and
- sign the cheque.

viii) Take the cheque to the second authorized cheque signer for approval and signature.

ix) Mail the cheque.

x) File the supporting cheque documentation by budget caption in separately titled file folders.

4. ISSUING PAYROLL CHEQUES

i) Calculate individual payroll amounts:

- salary: annual salary divided by number of pay periods during the year; or
- hourly: number of hours multiplied by hourly rate.

ii) Calculate source deduction by looking up gross pay in the source deduction books, i.e., Income Tax, Unemployment Insurance Commission (UIC) and Canadian Pension Plan (CPP).

iii) Calculate any other benefits.

iv) Insert the payroll styled cheques and earnings record cards onto the one-write system.

v) Prepare a cheque using the payroll one-write journal including:

- date
- pay to the order of
- cheque number
- gross amount
- UIC deduction
- CPP deduction
- income tax deduction
- net amount

vi) Post the gross amount of the cheque to the applicable payroll journal heading and the income tax, UIC and CPP amounts to their respective headings.

vii) Balance the payroll.

viii) Take the cheques and earnings records to the Administrator for approval and signature.

ix) Take the cheques to the second authorized cheque signer for approval and signature.

x) Mail or hand deliver the cheques to the appropriate employees.

5. REMITTING SOURCE DEDUCTIONS

i) Calculate the amount of income taxes, UIC and CPP withheld on behalf of the employees by referring to the payroll journal and the earnings cards.

ii) Calculate the employer's portion of UIC and CPP:

- UIC: Total withheld on behalf of all employees multiplied by 1.4.

- CPP: Total withheld on behalf of all employees multiplied by 1.0.

iii) Prepare a cheque that includes the amounts calculated in 5.i) and 5.ii) using the one-write system including:

- date
- pay to the order of
- cheque number
- description of why payment is being made
- cheque amount.

iv) Post the amount of the cheque under the applicable cash receipts and disbursements journal heading.

v) Take the cheque and supporting documents to the Administrator for signature. The Administrator will:

- review and approve the calculations;
- stamp the supporting calculations "PAID" and include a reference to the cheque number; and
- sign the cheque.

vi) Take the cheque to the second authorized cheque signer for approval and signature.

vii) Mail the cheque.

viii) File the supporting calculations by budget captions in the separately titled file folders.

6. ISSUING PETTY CASH PAYMENTS

i) Prepare a petty cash voucher and attach all expense receipts.

ii) Pay the individual with petty cash funds and request the individual to sign the petty cash voucher as evidence of payment.

iii) Replenish the petty cash fund when necessary by issuing a cheque from the health unit chequing account.

iv) Apply the regular procedures for issuing a cheque for goods and services.

7. EMPLOYEE ADVANCES

Issuing an Employee Advance

i) The employee will complete and sign an Employee Advance form.

ii) The Employee Advance form will be authorized by the Administrator. (In the case of an Administrator advance, the Board of Directors will approve.)

iii) Prepare a cheque.

iv) Post the cheque using the one-write system to the "Employee Advance" column.

v) Take the cheque and supporting documentation to the Administrator and second cheque signer for signature.

vi) Forward the cheque to the employee.

vii) File the Employee Advance form in the Employee Advance file, by employee.

viii) At month end, reconcile all outstanding employee advances to the general ledger.

Expense Reports

i) The employee will complete and sign an Expense Report form, attach receipts for all expenses, and attach a cheque for any excess advance.

ii) The Administrator will approve the Expense Report. (The Administrator's Expense Report will be approved by the Board.)

iii) The administrative/accounting clerk will

check the accuracy of the report and record the expense report:

a) if the employee is owed money, then a cheque will be issued, subject to regular cheque procedures;

b) if the employee owes money, then the cheque from the employee will be subject to regular cash receipts procedures.

iv) File the Expense Report in the Employee Expense Report file, by employee.

8. TRANSFERS BETWEEN CHEQUING AND SAVINGS ACCOUNTS

i) Transfers from the chequing account to the savings account will be done by issuing a cheque. Regular issuing of cheque procedures apply.

ii) Transfers from savings to chequing accounts will be authorized by the Administrator. (Note: Make sure that these transfers are recorded in the cash receipts and disbursements journal.)

9. MONTHLY PROCEDURES FOR THE ACCOUNTING CLERK

i) Reconcile the bank chequing account.

ii) Reconcile the bank savings account.

iii) Reconcile outstanding employee advances.

iv) Account for all duplicate cash receipts vouchers and that they have been included with the daily bank deposit.

v) Balance the cash receipts and disbursements journal and the payroll journal.

vi) Post the cash receipts and disbursements journal and the payroll journal to the general ledger.

vii) Balance the general ledger (called a trial balance) by making a listing of all general ledger account balances.

10. MONTHLY PROCEDURES FOR THE ADMINISTRATOR

i) Approve the bank chequing account reconciliation.

ii) Approve the bank savings account reconciliation.

iii) Approve the outstanding employee advance reconciliation.

iv) Count petty cash.

v) Approve the trial balance.

vi) Prepare monthly financial statements including:

- comparisons to budget;
- comparisons to prior year (after Year 1); and
- narrative explanations of all differences between actual monthly expenses and budgeted expenses and prior year expenses.

11. BOARD OF DIRECTORS PROCEDURES

i) Approve all budgets.

ii) Approve monthly and annual financial statements.

iii) Approve all employee compensation, including any changes.

iv) Approval all Board honoraria.

v) Approve all contracts, including contracted services.

vi) Approve all individual cheques greater than $5,000.

vii) Approve all banking arrangements.

viii) Appoint an auditor.

IV. REQUIRED FORMS AND SUPPLIES

1. **Bank Deposit Book** - as supplied by any chartered bank or credit union.

2. **Restrictive Endorsement Stamp** - order from any rubber stamp company. The rubber stamp should read "Deposit only to the account of _____ Health Unit, Account number _____".

3. **Cash Receipts and Cash Disbursements Journal** - see attached McBee one-write system forms. These are available from:

   McBee Technographics Inc.,
   569 Academy Road,
   Winnipeg, Manitoba.
   R3N 0E4

   (204) 489-5448

4. **Pre-numbered Duplicate Cash Receipt Forms** - are available from any office stationery company.

5. **Cheques** - see attached McBee one-write system cheques and forms.

6. **"PAID" Stamp** - order from any rubber stamp company. The rubber stamp should read "PAID", with a space for the date and a space for the cheque reference number.

7. **Petty Cash Voucher** - see attached petty cash voucher.

8. **Employee Advance Voucher** - see attached employee advance voucher.

9. **Expense Report** - see attached expense report.

10. **General Ledger Hardcovers** - are available from any office stationery company.

11. **General Ledger Pages** - are available from any office stationery company.

Approved By:

Number: XVII - 10

Date:

Category: Insurance

INSURANCE

The First Nation Health Authority has purchased comprehensive employers insurance coverage from the firm of Marsh and McLennan Ltd. The policy provides for:

- all risks property insurance
- comprehensive general and medial malpractice liability
- fidelity and crime insurance
- boiler and machinery insurance

All professional staff and contract personnel are required to maintain personal malpractice insurance coverage through their professional associations.

Health Authority vehicles are insured through the Manitoba Public Insurance Corporation.

Insurance claims procedures are the responsibility of the Health Care Administrator.

Approved By: **Number: XVIII - 10**

Date: **Category: Program Evaluation**

SUMMATIVE EVALUATION

The First Nation Health Authority has agreed to participate with the federal government in fulfilling the Minister of National Health and Welfare's obligations to undertake evaluations of initiatives under his direction which involve expenditure of federal funds (as specified in Treasury Board Policy Circular 1977-47). The Board of Directors agree to:

1. When reuested to do so, participate on an Evaluation Committee in conjunction with the Department to:

   a) plan and implement an evaluation of the short term impacts of the Health Transfer initiative to be completed no later than April 1, 1989 and to focus on at least the following issues:

      ° to what extent was the process of implementing transfer satisfactory, how has it evolved over time and how could it be improved:

      ° how did the transfer initiative operate as a way of transferring responsibility for community health services to Bands.

   b) plan and implement an evaluation of the longer term impacts of the transfer initiative to be completed no later than April 1, 1992, and to focus on at least the following issues:

      ° did the transfer initiative achieve its goal of transferring responsibility for health programs to Bands?

      ° to what extent has the arrangement resulted in Indian communities being able to design and deliver health programs in accordance with their own needs and priorities?

      ° to what extent have the Minister's requirements for accountability been met and are these requirements appropriate?

      ° did the overall health of Indian people improve under transfer?

      ° what have been the impacts, both unintended and intended on NHW and the Bands over the short and long term?

      ° are there other ways to achieve the transfer of responsibility for health services? What changes should be made?

2. Conduct, under Band management, an evaluation every five years of the effectiveness of community health programs, including an assessment of the achievement of objectives and impacts and effects of programs, and provide a copy of this report to "NHW".

With respect to the second point above, the Board of Directors will contract with a consulting agency qualified in health program evaluations to:

1) In year one of transfer:

   a) develop a comprehensive evaluation plan

   b) establish base line information

   c) identify evaluation indicators and data requirements

2) In year five of transfer:

   a) carry out a formal summative evaluation to meet federal requirements

   b) prepare a report to the Board of Directors of the Health Authority with recommendations for subsequent health program transfer agreements and funding arrangements.

Approved By:

Number: XVIII - 20

Date:

Category: Program Evaluation

FORMATIVE EVALUATION

Health Authority staff and advisory personnel will be involved in ongoing formative evaluation through the work planning process. Program development modifications require the concurrence of the Board of Directors. Program modifiations and development plans will be reflected in Annual Reports and five year budget projections.

Approved By:

Number: XVIII - 30

Date:

Category: Program Evaluation

QUALITY ASSURANCE/ACCREDITATION

The First Nation Health Authority will participate with Medical Services Branch and the Canadian Council on Health Facilities Accreditation in their pilot project to develop quality assurance standards and an accreditation for community health services.

Approved By:

Number: XIX - 10

Date:

Category: Personnel Policies

Health Authority staff will work in accordance with the personnel policies of Chemawawin First Nation and the provisions of any collective agreement provisions which may apply under ther terms of Interchange arrangements.

Approved By:

Number: XX - 10

Date:

Category: Staff Job Descriptions

HEALTH CARE ADMINISTRATOR

General Responsibilities:

The Health Care Administrator is the senior staff person of the First Nation Health Authority. The Administrator is responsible for establishing procedures to implement the policies of the Board of Directors of the Health Authority. The Administrator organizes and manages day-to-day operations. Major areas of responsibility include: personnel administration, financial administration, program supervision and liaison with other agencies and managing all arrangements for contracted or Tribal District Health Centre services.

Relationship:

The Administrator reports directly to the Board of Directors of the Health Authority. The Board is responsible for hiring, firing and monitoring the performance of the Administrator. All of the other staff of the Health Authority report directly to the Administrator.

Qualifications:

- certificate in health care administration or related post-secondary training in business or public administration.
- a minimum of one year experience in community health program administration, preferably in a remote native community.
- a capable manager and good organizer having the abilities to delegate responsibiliyy, be firm in decision-making, be able to get along well with people and communicate well both verbally and in writing.
- konwledgeable of the legal and institutional context of on-reserve community health programs.

Specific Duties:

Personnel Administration:

- assisting the Board of Directors in determining staffing needs and developing personnel policies.
- developing and implementing procedures for administering personnel policies of the Health Authority.
- recruitment, selection, monitoring, evaluating, promoting, orienting and dismissing of staff.

°development and updating of job descriptions.

°development of criteria for staff evaluation based on program objective job description duties and work plan targets.

°directing individuals in development and implementation of work plans aimed at meeting the program objectives of Health Authority.

°conducting regular staff meetings for the purpose of exchanging information, explaining policies, standardizing programs, adjusting workplans, evaluating activities and implementing new approaches or procedures.

°development of on-going training and inservice programs and opportunities so that staff members will be up-to-date in their program areas and motivated towards program development.

°work to maintain good staff relationships and morals.

Financial Administration:

°setting and maintaining operating and capital budgets annually and developing 5 year budget porjections.

°preparing cash flow and income statements on a monthly basis, balance sheets twice yearly and overall financial statements for audit annually — reviewing these fianancial reports and presenting to the Board.

°develop and manage an accounting system which includes up-to-date financial records, a system of controls and procedures to ensure accuracy, and regular preparation of financial reports.

°prepares annual report including audited financial statement and review of program achievement.

Program Supervision:

°direct a program planning process involving staff in:

-selection of program priorities consistent with assessed needs of the individual family and community.
-establishing appropriate work plans for staff.
-reviewing work plans against performance indicators and revising accordingly in consultation with the health team.
-identifying and instituting improved methods of program delivery.

°ensuring the completion processing, distribution, filing and maintenance of accurate patient and administrative records according to established procedures.

°ensuring the maintenance, proper functioning and timely replacement of clinic equipment, vehicles and facilities.

°ensuring that the work place is maintained in a safe condition and that health and safety procedures are adhered to.

°ensuring maintenance of an adequate inventory of supplies for clinic and office use.

°updating as required the community emergency response plans.

Liaison:

°receiving complaints and concerns from clients and assisting in resolution of those concerns.

°particpating in meetings and making presentations to band representatives and community organizations.

°maintaining regular contact with other on-reserve agencies, band administrative departments and relevant federal, provincial or private organization in order to ensure co-ordinated services are provided to the community.

Contract Service Administration:

°managing all arrangements for contracted or Tribal District Health Centre services including:
-visits of physicians, dental care teams, public health inspectors, the medical officer of health and other professionals:
-air charters:
-local medical transportation contracts and facility and equipment maintenance services.

Approved By:

Number: XX - 20

Date:

Category: Staff Job Description

POSITION TITLE: COMMUNITY HEALTH NURSE

General Responsibilities

The Community Health Nurse will participate with other members of the health care team in delivery of a proactive primary health care program to residents of the First Nation community. The nurse's primary duties will be to work in conjuction with other staff nurses and consulting physicians in providing primary care treatment and referral services and to take the lead role in delivery of family health care services to a portion of client families/households in the community.

Relationships

The nurse will report directly to the Health Care Administrator.

Qualifications

- Bachelor of Nursing Degree or suitable combination of formal training and experience
- Eligible for registration with the Manitoba Association of Registered Nurses
- Training and experience in primary care treatment and outpost nursing skills
- Nursing experience in remote native communities.

Specific Duties:

Primary Care Treatment

The nurse will operate within the Manitoba Association of Registered Nurses scope of duties for nurses providing primary care treatment and within the nurses own professional competency. Nursing competencies will be assessed according to Manitoba Association of Registered Nurses procedures. Duties will include:

- assessing health indicators of the communities so as to determine program needs and to organize treatment clinic schedules according to needs
- establishing an on call schedule to provide 24 hour emergency nursing coverage
- conducting outpatient clinics daily or as required. Providing 24 hour emergency treatment services on a rotational basis after clinic hours
- performing examinations of patients to determine requirements of in-patient or out-patient treatment or to determine whether medical attention is necessary
- performing diagnostic x-ray examinations

- performing simple diagnostic tests, HGB - sed rate - WBC and urine tests to determine the presence of infection or disease in the body.

- providing counselling services as a result of diagnosis and treatment given.

- scheduling follow-up examination and treatment as determined by condition.

- determining the need for evacuation of patients requiring emergency medical attention not available at the nursing station and making arrangements for the evacuation as well as providing nurse escort if patients conditions warrants as:

- providing 24 hour intensive nursing care of patients admitted to the nursing station for serious illness, observation or further investigation pending medical evacuation to hospital or discharge home:

- selecting patients from among the population served who require non emergency medical or dental care and arranging for their attendance at physicians at physicians or dental clinics:

- assisting visiting medical personnel with assessment, dispensing, appointments, etc..in the clinic as necessary.

Family Health Care

The nurse will be assigned lead responsibility for providing family health care services to a portion of the families/households in the community. The family health care program will be based on the Medical Services Branch Periodic Health Assessment Schedule. The nurse will be responsible for ensuring delivery as per the schedule and assessed client needs and for coordinating program activities with the members of the health care team. Program activities will include: regular home visits and clinic contacts with clients: examinations and tests: laboratory work: counselling: needs assessment: immunization and communicable disease control and participation in various coordinated activities including special clinics, prenatal classes, school health and health promotion events.

Health Records

The nurse will be responsible for client health records including: treatment charts: family health care charts: immunization status reports: communicable disease reports: birth and death records. The nurse will also be responsible for participating in the production of the Annual Report of the Health Authority.

Planning

The nurse will participate with other health care team members in ongoing work planning and program development to provide for coordinated and efficient services in all program areas.

POSITION TITLE: COMMUNITY HEALTH NURSE

Position Overview

The Community Health Nurse will participate with other members of the community health team in delivery of a proactive primary health care program to residents of the community of the First Nation. The resident community health team will comprise three community health nurses, two community health representatives, two substance abuse counsellors and a referral clerk. The resident health care team will be supported by itinerant physicians, dental teams, public health inspectors and other specialists. Professional nursing supervision and consultative support will be provided by the senior nurse educator employed by the Swampy Cree Tribal District Health Centre. Physician consultative support will be available by telephone on a 24-hour basis.

The Community Health Nurse will assume the lead role in delivery of a comprehensive family health care program to a portion of client families/households in the community and will work in conjunction with other staff nurses and physicians in providing primary treatment services. Requirements for care beyond the capacity of the community health team and clinic facilities will be handled through client referral to The Pas or elsewhere as appropriate.

Relationships

- The nurse will report directly to the Health Care Administrator of the First Nation Health Authority.
- Professional supervision will be provided by the senior nurse educator of Swampy Cree Tribal Council District Health Centre.
- Public health program monitoring will be provided by the Pas District Medical Officer of Health.
- Clinical skills assessment and certification will be provided through the inservice program of Swampy Cree District Health Centre.

Qualifications

- Bachelor of Nursing Degree or suitable combination of formal training and experience (certificate in public health, clinical skills, experience in remote Native communities).
- Eligible for registration with the Manitoba Association of Registered Nurses.
- Competent or willing to acquire competence within the scope of duties of expanded nursing practice in Manitoba. Skills assessment, inservice training and competency certification will be arranged through Swampy Cree Tribal District Health Centre.

Standards of Nursing Care

The First Nation Health Authority adopts and endorses the Standards of Nursing Care developed by the Manitoba Association of Registered Nurses as standards of care in the First Nation community.

Family Health Care Program

The Community Health Nurse will assume lead responsibility for delivery of comprehensive family health care services to a portion of the families/households in the community of the First Nation. The primary focus of the family health care program will be disease prevention and health promotion. The Community Health Nurse, in consultation and cooperation with other members of the health care team and within the scope of recognized nursing practice and his/her level of competence, will be responsible for all aspects of the nursing process with respect to assigned client families (assessment, planning, implementation including coordinated team action and referral, and evaluation). Family health care activities will include:

- implementation of regular program of health assessment and preventative care based on the Periodic Health Assessment Schedule developed by the Medical Services Branch of Health and Welfare Canada
- regular home visits to client families, needs assessment and follow-up as per nursing plan
- consultation and coordination of family oriented care with community health representatives and substance abuse counsellors
- participation in planning, coordination and team delivery of program services in the areas of maternal and child health, school health, adult care, communicable disease control, safety promotion and accident prevention, mental health promotion and health education.

Community Health Promotion

As a member of the resident community health team the nurse will be involved in identifying "hot spots" for community health promotion. Team members are responsible for targeting such areas for concerted team effort and developing and implementing strategies for effective intervention.

Public Policy Development

As a resident health care expert, the nurse will be responsible for advising the Board of Directors of the First Nation Health Authority on policy development in health and health related areas.

Primary Treatment Services

The nurse, in cooperation with other resident nurses and visiting and consulting physicians, will be responsible for providing primary treatment services within the scope of expanded nursing practice in Manitoba and his/her level of competence. Duties will include

- assessing health indicators of community so as to determine program needs and organization of treatment clinic schedules according to needs
- establishing an on call schedule with other nursing staff to provide 24 hour emergency nursing coverage
- conducting outpatient clinics daily or as required
- assessment of patients to determine requirements for in-patient or out-patient treatment or to determine whether medical attention is necessary
- performing diagnostic x-ray examinations
- performing simple diagnostic tests, to determine the presence of infection or disease in the body
- providing counselling services as a result of diagnosis and treatment given
- scheduling follow-up examination and treatment as determined by condition
- determining the need for evacuation of patients requiring emergency medical attention not available at the nursing station and making arrangements for the evacuation as well as providing nurse escort if patient conditions warrants
- participating in provision of 24 hour intensive nursing care of patients admitted to the nursing station for serious illness, observation or further investigation pending medical evacuation to hospital or discharge home
- selecting patients from among the population served who require non emergency medical or dental care and arranging for their attendance at physicians or dental clinics
- assisting visiting medical personnel with assessment, dispensing, appointment, etc. in the clinic as necessary

Performance Evaluation

The nurse will participate with other members of the resident and visiting/consulting health care team in ongoing evaluation of the community health program.

Nursing skills in assessment, planning, implementation and evaluation will be assessed upon initial employment and annually thereafter by the Swampy Cree Tribal District Health Centre Senior Nurse Educator. Inservice training plans will be implemented to develop and maintain necessary skills in all areas of nursing practice.

Approved By:

Number: XX - 30

Date:

Category: Staff Job Description

POSITION TITLE: COMMUNITY HEALTH REPRESENTATIVE

General Responsibilities

The Community Health Representative (C.H.R.) will participate with other members of the health care team in delivery of a proactive primary health care program to residents of the First Nation community. The C.H.R., in cooperation with the other staff C.H.R., will take a lead role in: health and safety surveillance and promotion: design and implementation of preventative and corrective health and safety measures: elderly and chronic patient home care: and nurse orientation to the community.

Relationships

The C.H.R. reports directly to the Health Care Administrator.

Qualifications

- completion of Medical Services Branch Community Health Representative training or suitable combination of formal training and experience
- fluent in Cree and English
- knowledgeable of community socio-cultural system and community health needs.

Specific Duties:

Health and Safety Surveillance, Prevention and Promotion

The two staff C.H.R.'s will work as a team with the assistance and advice of a consulting Public Health Inspector and the Medical Officer of Health to provide comprehensive proactive health and safety services. Program activities will include:

- health and safety surveillance involving water quality monitoring, waste collection and disposal system inspection, public and private facility inspections:
- quarterly reports to the Health Care Administrator on surveillance activities, results and recommendations for preventative or corrective measures:
- implementation of preventative or corrective measures:
- needs assessment, community education and organization of community projects.

Elderly and Chronic Care

C.H.R.'S in cooperation with nurses providing family health care services will take a lead role in providing for the health needs of elderly and chronic patients through regular home visits, needs assessment, health monitoring, counselling and assisting in implementation of the nursing plan of care.

Nurse Orientation

C.H.R.'S will have the lead roles in ensuring proper orientation of new nursing staff to the community and to his/her family health care client families/households.

Planning

The C.H.R.'S will participate with other health care team members in ongoing work planning and program development to provide for coordinated and efficient services in all program areas.

Approved By: Number: XX - 40

Date: Category: Staff Job Description

POSITION TITLE: SUBSTANCE ABUSE COUNSELLOR

General Responsibilities

The Substance Abuse Counsellor will participate with other members of the health care team in delivery of a proactive primary health care program to residents of the First Nation community. The Substance Abuse Counsellor in cooperation with other substance abuse staff will have the lead role in delivery of a preventative alcohol and drug abuse program and will authorize and ficilitate client referrals to out-of-community substance abuse treatment agencies.

Relationships
The Substance Abuse Counsellor will report directly to the Health Care Administrator.

Qualifications
NADAP training or equivalent.

Specific Duties:

Alcohol and Drug Abuse Prevention and Referral

Substance Abuse Counsellors are responsible for on-going assessment of community, family and individual needs and for priorizing and planning program activities to address those needs. The following provide a partial inventory of such program activities:

1) Primary Prevention Activity - Taking action before serious problems start to develop. A primary prevention activity results in the community wide distribution of information. These activities are mainly intended to prevent initial abuse. The following activities are considered primary prevention activities:

   a) Public Awareness Campaigns - a specifically planned and organized information "blitz" in the community. This may include one or more of the other primary activities.

   b) Public Meetings - a scheduled meeting where the Substance Abuse Counsellor has invited to speak at a gathering of community members.

   c) Public Speaking - primary activity where a Substance Abuse Counsellor has been invited to speak at a gathering of community members.

   d) Develop School Curriculum - a primary activity where the Substance Abuse Counsellor has met with school officials to create a component of the school's curriculum that deals with the abuses of alcohol, drugs or solvents.

   e) School Program - a primary activity where the Substance Abuse Counsellor has assisted a school teacher in teaching the effects of alcohol, drug or solvent abuse.

   f) News Media Work - a primary activity where television, radio or newspapers (Band Newsletter) is used to distribute information.

   g) Sponsor Spiritual Event - a spiritual event where the Substance Abuse Counsellor offers support of the event with the intention of making the community aware of the issues of abuse.

   h) Sponsor Cultural Event - a cultural event where the Substance Abuse Counsellor offers support of the event with the intention of making the community aware of the issues of abuse.

2) Secondary Prevention Activity - Early intervention: dealing with an existing abuse problem at the earliest possible stage. A program or event that offers an activity as an alternative to abuse is a secndary prevention activity. These activities are mainly intended to prevent abuse before it becomes a serious problem. The following activities are considered secondary prevention activities.

a) Recreational/Athletic - a program or event organized or sponsored by Substance Abuse Counsellors which is mainly recreational or athletic in nature.

b) Spiritual - a program or event organized or sponsored by Substance Abuse Counsellors which is mainly spiritual in nature.

c) Native Cultural - a program or event organized or sponsored by Substance Abuse Counsellors which is mainly cultural in nature.

d) Social - a program or event organized or sponsored by Substance Abuse Counsellors which is mainly a social gathering.

e) Other Group's Program - a program or event organized by another community organization in which Substance Abuse Counsellors particpate.

f) Discussion Groups - a program or event organized by the Substance Abuse Counsellors where community members meet to discuss any topic (not necessarily alcohol, drug, or solvent abuse).

3) Tertiary Prevention Activity - Maintenance: helping people to prevent a problem from returning. an activity that involves Substance Abuse Counsellors working directly with individuals, families, or groups to stop or prevent further abuse. The following activities are considered tertiary prevention activities:

a) Individual Counselling - a tertiary activity where a Substance Abuse Counsellor counsels an individual on a one-to-one basis.

b) Family Counselling - a tertiary activity where a Substance Abuse Counsellor counsels the family of a known or potential abuser.

c) Group Counselling - a tertiary activity where a Substance Abuse Counsellor counsels a group of known or potential abusers.

d) A.A. Group - a tertiary activity where a Substance Abuse Counsellor assists an Alcohol Anonymous organization with such activities as obtaining resource speakers, supervising meeting facilities, etc.

e) Alanon Group - a tertiary activity where a Substance Abuse Counsellor assists an Alanon organization with such activities as obtaining resource speakers, supervising meeting facilities, etc.

f) Alateen Group - a tertiary activity where a Substance Abuse Counsellor assists an Alateen organization with such activities as obtaining resource speakers, supervising meeting facilities, etc.

g) Crisis Intervention - a tertiary activity where a Substance Abuse Counsellor intervenes in a crisis situation because alcohol, drug or solvent abuse is involved.

h) Outreach Visits - a tertiary activity where a Substance Abuse Counsellor takes the initiative to make the first contact to an individual or family who could benefit from the prevention project's services.

i) Support Visits - a tertiary activity where a Substance Abuse Counsellor visits a known or potential abuser to reassure those involved.

j) Rehabilitation Referral - a tertiary activity where a Substance Abuse Counsellor refers an abuser to a rehabilitation centre or program.

k) Detox Referral - a tertiary activity where a Substance Abuse Counsellor refers an abuser to a medical Detox centre.

l) Medical Referral - a tertiary activity where a Substance Abuse Counsellor refers an abuser to a doctor or hospital for medical services.

m) Social Service Referral - a tertiary activity where a Substance Abuse Counsellor refers an abuser to a beneficial service offered by the Band.

n) Band Service Referral - a tertiary activity where a Substance Abuse Counsellor refers an abuser to a beneficial service offered by the Band.

o) Cultural Referral - a tertiary activity where a Substance Abuse Counsellor refers an abuser to a native cultural support group or person (elder).

Quarterly Reports

Substance Abuse Counsellors will prepare quarterly reports on program activities andk program development needs for submission to the Health Care Administrator.

Planning

Substance Abuse Counsellor will participate with other health care team members in ongoir work planning and program development to provide for coodinated and efficient services in all program areas.

Approved By:

Number: XX - 50

Date:

Category: Staff Job Description

POSITION TITLE: CLERK

General Responsibilities

The Clerk will participate as a member of the health care team in providing a proactive primary health care program to residents of the First Nation community. Primary duties of the Clerk include: referral arrangements: file and records management: medical and office supplies inventory management: reception and secretarial tasks: and acting as interpretor for patients not fluent in English.

Relationships

The Clerk reports directly to the Health Care Administrator.

Qualifications

- well developed office management and secretarial skills
- knowledgeable of community health facility operations
- fluent in English and Cree

Specific Duties

Referral Arrangements

- at the direction of staff nurses, substance abuse counsellors or consulting medical professionals makes all necessary arrangements for patient referrals to outside agencies.

File and Records Management

- ensures proper management and security of all health and office files and records

Medical and Office Supplies Inventory Management

- monitors medical and supplies supplies and ensures adequate inventories are maintained.

Reception and Secretarial

- acts as clinic receptionist, maintains appointment register and handles office correspondence and telephone calls.

Interpretor

° assists other health team members and clients in cases where communications problems arise.

Planning

° participates with other members of the health care team in work planning and program development to ensure coordination and efficiency in all program areas.

Approved By: Number: XX-60

Date: Category: Staff Job Descriptions

Position Title: **MAINTENANCE PERSON**

General Repsonsibilities

The Maintenance Person will be responsible for general maintenance of facilities and non medical equipment and for advising the Health Care Administrator of maintenance and repair requirements which cannot be handled in the community.

Relationships

The Maintenance Person reports directly to the Health Care Administrator.

Qualifications

- general knowledge of facility equipment, vehicle and engine maintenance
- good physical health
- ability to work independently

Specific Duties

Daily

- collect and dispose of garbage from nursing station and residence;
- incinerate garbage;
- disinfect containers and return to original location;
- replace garbage can liner;
- check transportation equipment for lubrication, fill with fuel, etc.;
- do any minor repairs necessary to transport equipment;
- ensure all transportation equipment is safe to operate;
- check all heating equipment, sewer, water and lighting fixtures to ensure generator is operating efficiently and to the desired levels.

Weekly

- check all light bulbs and fluorescent tubes and replace when necessary;
- special care and attention must be given to exit lights;
- check oil level, belt tension and drain condensate from tank of compressors;
- check oxygen supply;
- check fuel levels of stand-by generator, run for one hour once a week to ensure generator is operating efficiently and to the desired levels.

Monthly

- submit preventative maintenance and fuel reports to the Health Care Administrator;
- test emergency lighting by disconnecting the power to the emergency lighting for one hour and observe if the lights are operating properly and will last the required half hour;

° test the fire alarm system to assure bells, pull stations and smoke detectors are operating properly;
° check water levels in water supply tanks;
° alternate waste water pumps;
° check operation of fire pump.

Yearly

° check operation of fire pump and hose cabinets to ensure that none of the hoses have deteriorated, that the nozzles operate properly and proper flow rates from the fire pump.

Regular Duties

[As deemed necessary]
° clear snow off sidewalks, approaches to entrance/exit doors and steps;
° make sure the abpve are free of ice or packed snow;
° check to see that all exit/entrance doors and steps when necessary to keep clear of dirt or light snow;
° receive, unpack or pack and transfer incoming or outgoing supplies;
° move furniture when necessary;
° pick up and deliver mail when necessary;
° clean up work area, make sure tools and equipment are in the proper place and in safe working order;
° empty incinerator when necessary;
° operate transportation equipment when required;
° escort and guide when required such as for home visits, emergencies, etc.;
° interpret when necessary;
° keep grounds neat and clean (clean up garage, mow and rake);
° clean all light fixtures including light bulbs and fluorescent tubes when necessary;
° clean inside and outside windows a minimum of twice a year, generally spring and fall;
° clean all pipes, moldings, etc. where use of a step stool or step ladder is required and should be done twice a year, spring and fall;
° assist in stripping floors of old wax an re-wax;
° wash or scrub walls, ceilings, partitions and woodwork when necessary;
° perform minor carpentry work to buildings, walks, fences, etc.
° do glazing repairs when necessary;
° do minor repairs to such equipment as washing machines, vacuum cleaners, floor polishers, lawn mowers, plumbing fixtures and other small appliances;
° do minor electrical maintenance such as change burned out light switches and ballasts;
° service equipment for storage, prepare the ski-doos by greasing, blocking up, etc. and the same for the hondas, boats, etc. in fall;
° check all fire extinguishers on a monthly basis to ensure that they are in the proper location, that the pins are sealed in and the extinguishers have not benn fired off;
° instruct all new staff in the proper use of safety equipment such as fire extinguishers;
° instruct all new stafff in the proper use of hondas, ski-doos, etc.;
° act as safety officer for the nursing station;
° follow safety rules and procedures as established for the work location;
° clean fresh air and exhaust air grills;
° change air filters in air exchange units;
° clean fans;
° check vacuum cleaner bags.

Approved By:

Date:

Number: XX-70

Category: Staff Job Descriptions

Position Title: HOUSEKEEPER

General Responsibilities

The Housekeeper will be responsible for general upkeep of nursing station facilities and household supplies.

Relationships

The housekeeper reports directly to the Health Care Administrator.

Qualifications

- good physical health and organizational abilities
- able to work independently

Specific Duties

- maintaining the facility in clean and tidy condition
- ensuring household supplies and groceries are stocked and properly stored
- preparing and cleaning up after mid-day meal for staff, inpatients and visiting personnel
- facility laundry

Approved By:

Date:

Number: XXI-10

Category: Contract Services

ADMINISTRATIVE RESPONSIBILITY

The Health Care Administrator is responsible for all contract or Tribal District Health Centre service arrangements.